TRAUMA THERAPY AND CLINICAL PRACTICE

NEUROSCIENCE, GESTALT AND THE BODY

MIRIAM TAYLOR

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Trauma Therapy and Clinical Practice: neuroscience, gestalt and the body

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Trauma Therapy and Clinical Practice: Neuroscience, gestalt and the body

Miriam Taylor

Open University Press

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Praise for this book

"This important book is destined to become a classic in Gestalt therapy literature. Well-written, insightful, compassionate, and practical, it will assist many a therapist, guiding their approach to working with traumatised clients in ways that are up-to-date and well-informed. A great contribution!"

Malcolm Parlett, Visiting Professor of Gestalt Psychotherapy, University of Derby, UK (now retired)

"Miriam Taylor has done a simply tremendous job in articulating an expanded Gestalt approach to trauma treatment that is informed by, and integrated with, modern neurobiological approaches to trauma. Along the way she succinctly presents the general Gestalt phenomenological approach, allowing the reader to absorb our larger psychotherapeutic model as she builds from it her own particular approach to treating trauma clients. Miriam brings Gestalt therapy's experiential methodology to a clinical dilemma that is so rooted in disturbances of experiencing, while being informed by emerging knowledge about biological processes that maintain these disturbances in the nervous system post-trauma.

Importantly, in a field that has too often mistaken techniques of reducing trauma reactions as if they are coherent systems of psychotherapy, her book clearly places trauma treatment in a larger systematic vision of what it means to be a whole person through the lens of the Relational Gestalt psychotherapeutic endeavour. Miriam Taylor does this admirably, and her book shines with humanity. Her dedication, her compassion and caring, her concern for both her clients and also for her fellow therapists in service, and her voice for the restoration of an embodied and vital life for clients in healing, all resonate throughout her text. This book should be read by everyone treating trauma and I expect it to become a foundational text in our field."

James Kepner, Gestalt therapist and international trainer in Gestalt Body Process Psychotherapy, and author of Body Process: a gestalt approach to working with the body in psychotherapy, *and* Healing Tasks: psychotherapy with adult survivors of childhood abuse

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"Taylor's book is a theoretically and clinically sophisticated approach to working with trauma from a phenomenological vantage point. Although she references brain processes, the clinical power of this book is in how she integrates extant knowledge of the experience of trauma beautifully with her skilful, experiential, gestalt approach to working with the 'window of tolerance' and other trauma theory concepts. Her book had an immediate effect on my work."

Lynne Jacobs, co-founder, Pacific Gestalt Institute, USA

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For my family through all generations:
ancestors, contemporaries and descendants

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Contents

Acknowledgements xiii

1 Introduction 1
- Defining trauma 2
- Contemporary trauma therapies 4
- The traumatized body 6
- The application of neuroscience 8
- Reductionism and technique 10
- Gestalt as a therapy for trauma 11
- About the book 15

PART 1
Enlarging the field of choice 19

2 Making change possible 21
- Change from the client's point of view 21
- Introductory comments 22
- The Paradoxical Theory of Change and trauma 23
- Other factors in the change process 25
- Neuroscience, trauma and change 27
- Creating the conditions for growth 31
- Towards an Integrated Model of Change 35
- Summary 37

3 The organization of parts and wholes 39
- A metaphor for the work 39
- Orienting to trauma 40
- Trauma figure, trauma ground – field, self and other 41
- Creative adjustments 45
- Polarities, balance and holism 47
- Rigidity, chaos and complexity 49
- Restructuring the ground 51
- Summary 56

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4 Working with arousal 57
Trauma as a problem with arousal 57
Arousal and Gestalt 58
The autonomic nervous system 60
The Window of Tolerance Model 62
Working with arousal 65
Summary 71

5 There and then, here and now 73
The timelessness of trauma 73
Beyond the here-and-now 75
Differentiating experience 76
Awareness of the here-and-now 77
Awareness and the phenomenological method 78
Awareness, phenomenology and the process of change 82
The role of mindfulness in trauma therapy 84
Summary 88

PART 2
At the limits of self 89

6 From fear to safety 91
Avoidance, triggers and phobias 92
Responses to fear 94
Orienting to danger 95
The neurobiology of fear 97
Survival-based defences 99
Risky behaviour 101
Establishing safety 102
Case Study Part 1 106
Summary 108

7 From helplessness to autonomy 110
Helplessness and healthy process – a Gestalt perspective 111
Two kinds of helplessness in the body 112
The psychological impact of helplessness 115
Locus of control shift 118
Agency, choice and autonomy 119
Taking action 120
Case Study Part 2 125
Summary 126

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8 From disconnection to contact 128
Theoretical perspectives on dissociation 129
Depersonalization and derealization 131
Making sense of dissociation 131
Dissociation and the body 132
The fragmented self 135
Dissociation and relationship 140
Supporting contact 142
Case Study Part 3 145
Summary 146

9 From shame to acceptance 148
Shame through the lens of trauma 149
Shame as an attack on the self 152
Shame, blame and responsibility 153
Shame-full bodies 155
In an unreceptive world 158
Working with shame 160
Case Study Part 4 162
Summary 164

PART 3
A relational home for trauma 167

10 The role of the therapist 169
The therapist and change 169
Power and horizontalism 170
Establishing the relationship 172
The Polyvagal theory and social engagement 173
Transference issues 175
Therapist as (re)organizer 177
The therapist and emotional regulation 179
The therapist and the here-and-now 183
Summary 184

11 The well-resourced therapist 186
Personal story 1: gathering resources 187
Mirror neurons 188
Therapist vulnerability 190
Personal story 2: feeling wobbly 191
The embodied therapist 193
Personal story 3: an expanded window of tolerance 196
Mindfulness as a resource 200

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Mutual healing 201
Summary 201

12 Embodied relationship 203
Relational dilemmas 203
What we already know 204
Mutual regulation 207
An experience beyond words: making sense together 211
Touch 215
Special considerations in tolerating relationship 217
Summary 218

13 Transforming relational wounds 219
Disorganized attachment and complex trauma 219
Rupture and repair in trauma therapy 221
Dysregulation and the window of tolerance 222
Surviving ruptures 224
What's going on? Trauma made manifest 225
Acts of triumph 228
Integration, narrative and earned attachment 230
Case Study Part 5 232
Summary 232

Glossary 234
References 238
Index 251

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1 Introduction

> We all hover at different distances between knowing and not knowing about trauma, caught between the compulsion to complete the process of knowing and the inability or fear of doing so.
>
> (Laub and Auerhahn 1993, in Bromberg 2001)

Trauma, by its very nature, creates splits at multiple levels. Traumatic events are not isolated occurrences, and the inner experience of the traumatized individual becomes reflected in the wider world. Stolorow accurately speaks of 'Traumatised people living in a discrepant world' (2007: 13). For the victim, splits occur in the continuity of their experience, in the coherence of **self**, and in the stability of the **ground**. Their experience is decontextualized. For those around them, there is often denial, disbelief, alignment with the perpetrator, blame or over-protectiveness. Trauma draws us personally to things we would rather not know about ourselves, and we respond by blotting them out. In the wider societal **field**, including the legal system, media and the political arena similarly polarized positions exist. Traumatic reactions spill over from the individual to the collective in parallel processes which maintain and reinforce the trauma (Soth 2007: 74), and no one is immune from them. The effects of this are profoundly deadening, and this book sets out to explore how to revitalize those individuals most affected, safely and effectively, without overwhelming or retraumatizing them.

To understand trauma we need to bring together the capacity to engage in complex thinking, the capacity to bear witness to random events and acts of extreme cruelty and the ability to manage chaos, moral outrage and intense emotions. This is no small undertaking as we make new meanings out of utter destruction. It takes courage, honesty and integrity to do so. Personally and collectively, splitting becomes a natural response to managing the feeling of overwhelm; it makes trauma containable because

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it presents in small packages. To different degrees we dissociate from traumatic experiences making them less personal, less real. With such divisions, it is a challenge to take on new perspectives or attitudes, and over time such positions become embedded and entrenched. According to Hillman we engage in dichotomized thinking for comfort at the expense of clarity (1996: 129), and creativity and coherence suffer likewise. Once trauma is imprinted in the very fibres of an individual or social group, flexibility, choice and growth do not ensue. Particular therapeutic challenges of integrating theory, selfhood and relationship are explored in each of the three parts of the book.

The integration which is widely accepted as a good outcome for trauma therapy is not simply a matter of reassembling the broken parts, as with a jigsaw puzzle. It is necessary to find a way of differentiating experience in order to make a whole that has not previously existed. We do so by understanding the organization of relationships and connections between the parts. There is an appropriate metaphor for this process in human anatomy, where connective tissue throughout the **body** both forms partitions and connects: 'We cannot form connections unless we start at a place of separateness' (Stauffer 2010: 145). In trauma, the process of fragmenting is driven physiologically, psychologically and relationally. In recent years we have learnt much about the impaired connectivity in the brain which results from trauma (see for example Cozolino 2002: 257; Siegel 2003: 16). We can conclude that we need to rebuild a trauma victim's life from the cellular upwards, holding micro (individual) and macro (field) dimensions together.

The process of differentiation is intrinsic to Gestalt psychotherapy and is one of its clear strengths. The phenomenological method is an excellent vehicle for differentiation. From a Gestalt perspective, splits describe the basic conflict between self-and-other which is inherent in trauma, while differentiation of experience is the forming of self in relation to other, by clarifying and strengthening. This then gives the trauma a new context and way of shaping and containing. We need to gather a coherent theoretical, relational and phenomenological framework around the experience of trauma that embraces new insights and knowledge. It is this task the present volume seeks to fulfil, encompassing the integrative potential of Gestalt.

Defining trauma

Traumatic events are usually defined as being life threatening, exceeding the victim's normal resources. Put rather crudely, trauma is something that cannot be coped with. It is a moment in which everything is undone.

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There is usually an overwhelming sense of shock and an inability to escape in the face of unforeseen events. People who witness traumatic events are equally vulnerable to trauma reactions, becoming victims themselves. Trauma is so often bound up directly or indirectly with relationship. For people living in abusive or violent families, trauma is not an event but a relationship. The victim's instinctive cry for help underlines the importance of relationships for survival. According to Cozolino, 'interpersonal trauma is more likely to be self-perpetuating and resistant to healing' (2006: 229). Trauma breaks the bonds of attachment and security which we understand to be the bedrock of a stable and coherent sense of self. Bromberg calls trauma a 'precipitous disruption of self-continuity' (2001: 11).

With this absolute breach between the individual and their known world, there are few resources to fall back on; there is no 'I' who knows how to alleviate this situation. Nothing – *but nothing* – is familiar, reliable, continuous or trustworthy. Unsurprisingly, therefore, trauma victims feel as though they have instantaneously been transported into a different existence. Stolorow, reflecting on a personal experience of trauma writes:

> Massive deconstruction of the absolutisms of everyday life exposes the inescapable contingency of existence on a universe that is random and unpredictable and in which no safety or continuity of being can be assured . . . as a result, the traumatized person cannot help but perceive aspects of existence that lie well outside the absolutized horizons of normal everydayness.
>
> (2007: 16)

Most trauma clients hover somewhat above direct lived experience alternating between moments of extreme and uncontrollable arousal, both too distant and too near.

With the right support, most people who have experienced traumatic disorganizing events will recover and never come to the attention of therapists or psychiatrists for the symptoms of post-traumatic stress disorder (PTSD). It is estimated that between 25 and 30 per cent will go on to develop PTSD (Herbert 2012: 511). Resilience factors differ from one individual to the next. Those who suffer a 'single event' trauma in adulthood often benefit from simple and brief interventions. They are not really the concerns of this volume, because traditional ways of working seem to help.

Clinical practice suggests that when individuals do develop severe symptoms after a single traumatic event there is usually an underlying deficit, typically due to early relational factors. Bromberg observes that individuals who have suffered massive trauma as adults who also had a

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developmental history of disconfirmation were 'typically more debilitated by the later event than were victims of adult onset trauma who did not have such a developmental history' (2011: 58). The complexity of responses to trauma can be seen on a continuum (Briere and Spinazzola 2005), contingent upon the severity and duration of the trauma, the developmental age of the victim and the level of social support available. Thus we arrive at the concept of complex trauma, which is often less responsive to traditional therapy. Clients in this category need a more considered and informed approach to therapy, which is the subject of this book.

It is rare to find a psychiatrist who considers PTSD from the outset. It is common for complex trauma clients to arrive with a string of other diagnoses and failed treatments, from depression to anxiety, from bi-polar disorder to obsessive compulsive disorder (OCD). They may also be treated for eating disorders, substance abuse and self-harm, or carry a personality disorder label. This is not to say that these problems do not also exist; trauma clients who come for therapy often have multiple concurrent problems. In their own right, PTSD symptoms as part of complex trauma are extremely debilitating, and these clients suffer greatly. For these reasons, Davidson describes the 'all-too-heavy cost of PTSD, which, by any standards, must be viewed as among the most serious of all psychiatric illnesses' (2000: 3). What the following pages will show is that this extraordinary suffering need not be a life sentence.

Contemporary trauma therapies

There is some overlap between approaches to trauma therapy, especially in relation to a phased approach to therapy and the need for a preliminary setting of the conditions in which the trauma can be processed. It has been understood for decades that trauma needs to be worked with in stages, the first stage usually being associated with stabilization before trauma can be processed (Herman 1992: 156). Cognitive-Behavioural Therapy (CBT) for trauma, which is often presented as the therapy of choice, actually represents a 'broad class of therapies unified by a shared emphasis on observable outcomes, symptom amelioration, time-limited and goal-oriented intervention, and an expectation that patients will assume an active role in getting better' (Monson and Friedman 2006: 1). As we shall see (Chapter 2), this last point is extremely problematic for trauma victims. CBT trauma therapy aims for individualized treatment plans, combining embodied schema therapy with standardized protocols. While CBT is effective for some trauma clients, it does not provide a cohesive theory of trauma. Herbert, originally a CBT therapist herself, makes a number of criticisms of this approach for trauma clients. She argues that a sole focus

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on protocols will not meet the complexity of these clients' needs, risking that clinicians will treat all trauma clients in similar ways (2006: 148). CBT methods tend to rely on 'top-down' processing and pay less attention to the somatic dimensions of trauma as suggested above.

Furthermore, some CBT therapists use prolonged exposure techniques with trauma victims (Riggs et al. 2006: 65), which clients may be unable to tolerate without becoming retraumatized. Van der Kolk et al. state this: 'Flooding and exposure are by no means risk-free treatment techniques. Exposure to information consistent with traumatic memory can be expected to *increase* anxiety (thereby sensitizing and aggravating PTSD symptomatology)' ([1996] 2007a: 431, my italics). Complex trauma clients may already be suffering from too much exposure in the form of flashbacks, nightmares and intrusive memories.

Dialectical Behavioural Therapy (DBT, Linehan 1993) combines CBT techniques with skill training for mindfulness and emotional regulation. DBT was originally proposed as a combined individual and group therapy, but is rarely offered as both. Alongside the benefits, there seem to be some obvious problems with CBT approaches for trauma. According to Denham-Vaughan, cognitive approaches are predicated on both objective reality and on lack of awareness or inability to use reason to deal with that reality (2005: 10), a position incongruent with neurobiologically informed trauma therapy. 'Although cognitive approaches, including interpretation and verbal response to interpretation in therapy, are the left hemisphere's necessary contribution, they are never in themselves enough' (Schore 2007, cited in Wilkinson 2010: 10). Denham-Vaughan observes further that 'Will-based' psychotherapies – such as CBT . . . can inadvertently reinforce . . . feelings of failure' (2005: 8). Having said this, the structure of CBT sessions and the brief time frame may be containing for some trauma victims in the early stages of therapy.

Eye-Movement Desensitization and Reprocessing (EMDR) was developed as a technique which helps to process difficult experiences, and is usually used with trauma victims. It involves the use of a protocol to provide successive short bursts of bi-lateral stimulation while the client focuses on a problem, interspersed with periods of reflection. It is a powerful and direct technique which brings the client rapidly in touch with charged material in carefully titrated doses. Figgess has provided an interesting integration of EMDR and Gestalt (2009). CBT and EMDR approaches sometimes overlook the prolonged length of time it can take to help a client feel more stable. Clinical experience has provided many instances of people for whom either approach has failed or retraumatized them.

The same criticisms cannot be made, however, of Sensorimotor Trauma Therapy (Ogden et al. 2006), which comes closest to Gestalt

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therapy. Sensorimotor Psychotherapy emerged from the ground of trauma research. It was developed in the 1990s by Pat Ogden, a collaborator of Kurtz. Ogden had been a body therapist and Rolfer, and she brought her experience initially to apply physical work to Kurtz's Hakomi method (2007). Kurtz had been influenced by his work with Perls and others (Ogden, personal communication, 2011), and Gestalt therapy can clearly be seen as one of the roots of Kurtz's approach. So Sensorimotor Psychotherapy is in the position of 'step-grandchild' to Gestalt. A number of the methodologies offered by Sensorimotor work are derivatives of Gestalt, such as tracking, **contact** and **experimentation**. However, Sensorimotor Psychotherapy does not identify with any particular psychotherapeutic modality. While the theoretical base of Sensorimotor work is very different from Gestalt, being focused on trauma, there is much that is not only compatible with Gestalt, it can also add some valuable ideas (see Taylor, 2013).

The traumatized body

Janet, as the forefather of trauma therapy, agreed with Freud on the significance of physiological reactions to trauma. He wrote that 'intense emotions are dissociated from consciousness and are stored as visceral sensations (anxiety and panic) or visual images (nightmares and flashbacks)' (1904, cited in van der Kolk et al. [1996] 2007c: 309). Kardiner, writing in 1941, noted that sufferers develop an enduring vigilance for, and sensitivity to, environmental threat, and described extreme physiological arousal in these people, including sensitivity to temperature, pain, and sudden tactile stimuli. Later, van der Kolk's seminal paper on the neurobiology of trauma entitled 'The Body Keeps the Score' (1994) brought together a series of interconnected neurobiological findings. Van der Kolk's writing is highly technical, and provides much evidence of the changes to brain functioning that arise from traumatic events. This paper was the first to really point the way to working somatically to heal trauma. Van der Kolk states that psychological effects of trauma are expressed as changes in the biological stress response, and we will consider this further in Chapter 4.

Apart from its psychological (loss of self) and relational impact (loss of secure connection), there is no doubt that trauma has significant effects on the victim's physiology. At the moment a trauma occurs a cascade of physiological changes takes over, preparing the victim to take instinctive defensive actions. Immediate alterations in heart rate, respiration, muscle tone, circulation, digestion and state of alert are supported by a flood of neurochemicals related to stress – adrenaline and cortisol in particular.

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The essence of panic and extreme fear is visceral. The stamp of that moment of severance becomes embodied – terror, helplessness and disconnection are preserved in the tissues and cells of the victim. The body really does keep the score.

Clinical vignette

Mark went to an osteopath crippled by back pain. The treatment had limited benefit, and it was only when the osteopath commented 'It feels as though you've had a shock in the past' that the penny dropped. Fifteen years previously, Mark had an accident at work, falling from a ladder. His most serious injury was to his leg, and he had surgery to repair complex fractures. But he didn't connect his back pain with this event. The osteopath's comment triggered memories of falling, and paralysing fear of landing on his back. With the encouragement of his osteopath, Mark came into therapy.

Some time later, Mark was able to reflect on what happened. He told me, 'After my accident, everything felt like chaos, complete chaos, I couldn't handle it, I'd become someone different. That constant sense of urgency, telling myself "Do something, do something" but I couldn't. I just couldn't get away from those feelings. I can see it now, how it's been like my head pulling me forward ever since, all up in my head, still far away from the ground. Waiting, waiting, bracing myself for the thud, over and over, like living in free-fall, nothing I could *do. Now I'm learning to be less afraid of feeling my back, I know where the ground is, I feel completely different. It's not in my head now, I'm slower, more present, I can think . . . and my pain has disappeared.'*

It is at the embodied level that victims remain most exposed to trauma, and many clients experience their bodies as the cause of their distress. Over long exposure, primarily through repeated early trauma, damage to structures in the brain takes place. The particular violation of bodily integrity as a result of physical or sexual assault radically alters the victim's relationship to their embodied life. In adult life, many victims of early trauma have physical health problems – digestive, endocrine, cardiac, respiratory, vascular and auto-immune systems all being potentially vulnerable.

> The experience of trauma . . . calls into question our relation to 'having a body' and 'living in a body' and makes profoundly troubling the centrality of the body in human existence and the body's claims upon us . . . And yet it is undeniable that severe trauma is

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> inscribed in and often on the bodies of survivors, leaving a mark that can perhaps be explained but never effaced.
>
> (Young 1992, cited by Armsworth et al. 1999: 139)

The enduring mark of trauma is borne out of what is initially a healthy reaction, the survival instinct, to strikingly abnormal events. This is later maintained by the body's attempt to resolve the trauma. We will consider this in detail in Chapter 7. It is the body primarily that seeks recovery, but does so in vain. All the physiological processes involved continue inexorably regardless of the conscious intentions or wishes of the victim. It is no wonder then, that trauma victims so frequently report feeling out of control. They are powerless over their own intense embodied reactions to what happened. When the body doesn't know how to repair itself it becomes alienated, split from its meaningful contribution to everyday life. Trauma victims can no longer feel the beat of their own heart or the stirrings of desire, and it can even be dangerous to feel them. So the heart ails and desire contracts into the musculature. Gestalt body process work is predicated on trusting the body to know what it needs; for trauma clients this basic trust urgently needs to be restored.

In order to address these profound splits we need to understand the relationship between body and mind. If we change the body we heal the mind at the same time (Johnson 1995: 169). A cultural and linguistic split concerning body and mind persists. As van der Kolk observes: 'Brain, body and mind are inextricably linked, and it is only for heuristic reasons that we can still speak of them as if they constitute separate entities' (1994). The brain is more than the matter within our heads, it is the entire nervous system, which, according to Kepner, distributes energy throughout body (2002).

Another body metaphor is indicated in Johnson: 'The indissoluble functional and somatic unity of the sensory-motor system is testified by the obvious structural and bodily unity that is built into the spinal column' (1995: 344). This is more than an individual function for we need to recognize the role of the nervous system in mediating our interactions with the outer world. Because it concerns the self in the world which is so compromised by trauma, we can claim that healing of the body is the essence of good trauma therapy. This is not as complicated as it sounds, for neuroscience has provided us with some clear indications of how this can be achieved and these are described throughout this book.

The application of neuroscience

It is all too easy to pathologize in a pejorative way that which we cannot explain, implicitly blaming the client for their suffering. Fortunately, what

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we learn from neuroscience gives us a new window on some of the difficulties encountered in traditional psychotherapy. Trauma has been intensively researched by neuroscientists. For these clients it may even be harmful to ignore what neuroscience is telling us. Neuroscience represents a link between phenomenology and physiology. Most importantly for trauma therapy, it gives us insight into disconnections within the brain and processes that are not under voluntary control. This has huge implications for the way we understand the process of change and growth in psychotherapy, and informs the choices that may or may not be available to our clients. This is the subject of Chapter 2 in particular, but we return to it throughout Part 1. Neuroscience also shows us that recovery from trauma will not happen in the usual time frames proposed by health providers.

Neuroscientific research focuses on different aspects of the nervous system. It has diverse branches of study, of which there are three that are of primary interest to trauma psychotherapists. First, a variety of neuroimaging techniques are used to investigate the structures of the brain including neural circuits. The most commonly used of these techniques in trauma research is fMRI scanning, the 'f' referring to the function of different structures. This is done by observing blood flow to these areas, indicating changes in activity in them. Fogel sees the notion of modularity in the brain as conceptually useful in attributing regions of the brain associated with particular activities – all are always involved – which may be helpful clinically but not scientifically accurate (2009: 42). Wilkinson helpfully points out that the 'time frames involved in fMRI studies are vastly different from the time frames of therapy' (2010: 191–2).

A much more detailed study of neural activity at a cellular level is provided by magnetoencephalography (MEG) which measures electrical activity. These studies point to particular deficits in brain functioning of trauma victims and suggest new ways of thinking about and working with them. One thing that we can learn from this is the concept of neuroplasticity, which demonstrates that even at microscopic levels in the brain, growth is possible. How to harness that growth is the challenge for trauma therapists, as we shall see.

A second branch of neuroscience is related to the study of neurochemicals, the substances that are secreted by the brain and other organs to maintain the balance of life. These include hormones, proteins, neuropeptides and neurotransmitters which influence the firing, growth and specific function of neurons. Some of these neurochemicals have a soothing function, while others are associated with states of stress and danger. For someone who has experienced severe trauma, there may be toxic levels of these stress-related chemicals, which eventually become exhausted and depleted and no longer serve to protect the individual. Dissociation is

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driven in part by a neurochemical reaction, and this is explored in Chapter 8. 'The presence of high levels of chemicals produced by the endocrine system in the blood stream may also suppress the immune system and account for increased physical illness in some chronically fearful clients' (Cozolino 2002: 251–2). Implicit in this is that trauma therapy will reverse the proportions of neurochemicals associated with stress and well-being. The relevance of this is discussed in Chapters 4 and 12.

Linked to this is the area known as affective neuroscience. This is the study of the neurology of emotion, mood and personality. Specific areas and networks in the brain seem to interact in individual emotional states. This has given rise to the understanding that there is a fear circuit involving certain areas of the brain under conditions that are traumatic, which gets reactivated whenever the victim is reminded of the traumatic event; this is explored further in Chapter 6. Because this branch of science is concerned with emotion, we can infer that it is also to do with relationship and connection with others. The implications of neuroscience reach far beyond the investigation of the brain as an organ in isolation.

Reductionism and technique

Essential though the new knowledge of neural processes is to trauma therapy, we have to be cautious about privileging science over relationship, subjective experience and the essence of human existence. As Cook says, '[science does] not account for all experiential phenomena and attempts to rationalise them can end up denying the experience' (2012: 31). The therapy room is not a laboratory, and the vigilant observations of the therapist do not stand in for the microscope or fMRI scanner. The science therefore can be seen as a valuable representation, or a metaphor for emergent subjective processes. It is a probability rather than a certainty about what underlies the phenomenological experience. We can also argue the case that to avoid phenomenological or 'subjective' evidence is unscientific.

We may choose to think of neuroscience as reductionistic, but it is not necessarily at odds with a holistic stance. Paradoxically, we can apply our understanding of neuroscience in a way that is ultimately integrative, by holding in mind that in order to differentiate we need to separate and discriminate. 'We can be open to the effects of neurological impairment while emphatically not saying that all psychological problems are reducible to such impairment' (Philppson 2012: 87). We need to be able to find a way to let the science inform us, to let go of it while at the same time knowing it. It must sink into the ground of our practice in such a way that it does not interfere with subjective experience, meaning-making and

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the relational field which are at the heart of Gestalt. This adds to the complexity of our approach rather than limiting it. These ideas will be taken up through different perspectives later on.

It is an oversimplification to translate the science into techniques, although certain kinds of interventions have been shown to be beneficial. Yontef argues that 'An accurate understanding of the phenomenological basis of these techniques protects against making the experiment into an instrument of directed change, as in behaviorism' (2005: 94). Neuroscience offers therapists this kind of accuracy. It is perhaps stating the obvious to say that 'techniques and interventions are relational' (Boston Change Process Study Group 2010: 196), however 'we should clearly distinguish between a merely technical attitude, focusing on *something* in terms of processes, mechanisms and dispositions, and a therapeutic attitude that uses techniques, but goes further, addressing *somebody* suffering, being impaired or injured' (Fulton et al. 2009: 28, original italics). There is a clear case for *skilful and informed* intervention in trauma therapy. 'Obviously, certain tasks, including many that involve an interaction with another person, require both individual mastery of some technical skill and that this skill be incorporated within relational spontaneity' (Bromberg 2011: 123).

Gestalt as a therapy for trauma

From its inception, Gestalt therapy has taken an interest in making whole, a word derived from the old English word for healing. The focus is on perceptual and experiential wholes and how they are related and organized. By implication, Gestalt also takes account of disconnection and separation. These relationships are discussed further in Chapter 3. Gestalt therapy has a unique understanding of holism, grounded in Lewinian field theory (see Lewin 1997), providing a context for the experience of the individual client, including the organismic or physiological. For Gestalt therapists, self-and-other (also referred to as environment or field) are seen not as separate entities but indissoluble, self being a function of the field. These complex and sophisticated notions cannot be defined succinctly and are the subject of extensive literature (see for example Wheeler [1991] 1998; Philippson 2001, 2009). Parlett stresses the importance of this thinking, saying: 'Arguably, overcoming self-world dualism or the split between parts of the unitary field is one of Gestalt therapy's most radical contributions' (2011: 54). At the heart of the self-and-other orientation lies the universal existential dilemma of who I am in the world.

Perls' conceptualization of self-and-other was influenced by the year he spent early in his career as an assistant to neuro-psychiatrist Kurt

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Goldstein. Far ahead of his time, Perls intuitively anticipated the findings of neuroscience research. 'In keeping with his holistic attitude, Perls valued human qualities and activities associated with both the left and right hemispheres of the brain' (Clarkson and Mackewn 1993: 36). He could not have foreseen that the accuracy of some of the central propositions of Gestalt theory would later be validated by neuroscience. A retrospective linking of the two and their application to trauma is made throughout this volume. The freshness of Perls' thinking has too often been overshadowed by his delivery of famous (and infamous) demonstrations of technique. As Elaine Kepner put it: 'How is it that so many have mistaken the medium for the message in Gestalt, and have confused the techniques and gimmicks for the essence of the method?' ([1980] 2000: 6). Some Gestalt formulations of theory have been subsumed under different banners, which again dilutes the message.

The integrative capacity of Gestalt's holistic stance has nevertheless been understood by others from outside the modality. A psychoanalyst's (Tilmann Moser) view of the strengths of Gestalt therapy is recorded by Bocian: 'For the first time there are therapeutic approaches that offer different possibilities of making diagnostically visible and of enacting . . . divergent parts of the self' (2009: 40). Similarly, Bromberg, in reference to Mayer, says 'the Gestaltists have shown us the key . . . to become adept at moving between one [coexisting anomalous part] and the other, holding the memory of [one] even as we see the [other]' (2011: 138–9). More specifically, Cozolino regards Gestalt as being uniquely relevant to the notion of integration at the neuronal level (2002: 60). According to him, it is the focus in Gestalt on 'bringing to conscious awareness the automatic, non-verbal and unconscious processes organized in the right hemisphere and subcortical neural networks', maximizing awareness of all aspects of the self that supports the process of integration (Cozolino 2002: 61).

Contemporary Gestalt practice represents a qualitatively different paradigm from that of its founders. Although it was not obvious from Perls' demonstrations and verbatim accounts, Gestalt was distinctively primed as a relational therapy because of its theory of self. This book follows the relational turn in general psychotherapy, which in Gestalt was first articulated by Wheeler (1998, 2000), Hycner (1993) and Hycner and Jacobs (1995). Trauma is contextualized as part of the relational field which allows for integration, differentiation and processing. Take for example the empty chair technique, so often (and mistakenly) perceived as the main contribution of Gestalt. Classical Gestalt practice might use this in an overly provocative manner, assuming a certain robustness and voluntary control on the part of the client not usually available to traumatized individuals.

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Compare this to Spagnuolo Lobb's more relational version: 'The technique of the empty chair is replaced by saying *to the therapist* – instead of to the chair – what the patient would say to the person or part of her/himself placed on the chair (Müller, 1993). This change enables us to bring into the core of the situation, into the field of the present relationship, the relational block' (2009: 118, original italics). Thus splits and conflicts are held within the therapeutic relationship.

Gestalt therapy continues to value the immediacy of the present moment, encouraging spontaneity and authenticity of contact. This permits reorganization of the experiential and relational field. The ways in which individuals adjust to trauma are treated in Gestalt as creative and the very best a person can do in difficult circumstances. Too often, however, they arise from a field of severely limited choice, and become incorporated into the structure of the personality as **fixed gestalts**. For Gestalt therapists, fluidity of response is a sign of healthy process; a sign of an expanded field of choice.

Differentiation is supported by the phenomenological approach, replacing the 'why?' with 'how, where and when?' (Perls [1947] 1992: 106). Gestalt does not propose a theory of causality and we cannot therefore claim that trauma has certain consequences. Rather we understand that the response to traumatic events is uniquely subjective, individual and field sensitive. Gestalt therapy has evolved as a sophisticated and finely nuanced approach, which by embracing a deep humanity and understanding of suffering has much to offer trauma victims.

Having said this, there are of course limitations in Gestalt. One in particular is relevant to the present discussion of splits between body and mind. Brownell describes 'residual' dualisms in Gestalt therapy: 'we need to understand how an immaterial "self" is related to the "conservative" and material physiology of the organism' (2009: 72). Conceptually, body process is central to Gestalt thinking, as articulated by Kennedy (2005). The body is seen in Gestalt as valuable for heightening **awareness**, but this does not necessarily lead to a deep integrated embodiment. Many Gestalt therapists have not been sufficiently trained to know how to follow through with body awareness. Training institutes rarely teach students about the mechanics and systems of the body, leading to a pervasive lack of confidence in knowing what to do and how to apply it. A differentiated approach would seem to indicate this is necessary. Rather, we have at present to go outside Gestalt to other bodywork traditions in order to fill this gap, as a number of Gestalt body therapists have done. Chapter 11 includes a personal account of such development.

Because Gestalt addresses some of the essential dimensions of human functioning and of being in the world, it has traditionally been thought of as universally applicable regardless of the client's presenting difficulties.

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Those who represent this line of thinking are concerned that the spirit and integrity of Gestalt is lost by changing its parameters. On the other hand, we can argue that certain large groups of clients, including those who have experienced trauma, merit particular understanding of their difficulties. This view is represented by Yontef (1993) and his work on personality disorders, by Oaklander (2000) and McConville (1995) and their approach to working with children and adolescents, and by Kepner and his contribution to working with childhood abuse.

Kepner's model

Surprisingly, there is at the time of writing only one significant work on trauma in the Gestalt literature, James Kepner's *Healing Tasks* (1995), specifically focusing on childhood abuse. James is the son of the aforementioned Elaine; he is hereafter referred to as Kepner. His important book is steeped in Gestalt values, and consistent with the spirit of the human potential movement. Drawing on clinical experience, Kepner presents many creative ideas for interventions, but more often than not these are not defended theoretically. For this reason many of the interventions are difficult to translate into clinical practice. Published a year after van der Kolk's 'The Body Keeps the Score', the impact of neuroscience had not yet been felt. However, Kepner's message can be taken as being absolutely consistent with the principles of neuroscientifically informed trauma therapy. Therefore, while there remains much to commend in Kepner's work, it does need updating and grounding in a stronger theoretical base.

Kepner was among the pioneers of contemporary trauma therapy who advocated a phased approach to the work. His Healing Tasks Model is a stroke of genius, providing a hologrammatic, integrative, and nonlinear framework for the process of therapy (see Figure 1.1). This reflects accurately the recursive phenomenology of trauma clients, and defines the key therapeutic tasks within each overlapping phase. As Kepner explains, the four phases of his model are arrayed across the top of the diagram, and the four tasks are arrayed in the columns. Shaded boxes represent tasks that are more in the background during a particular phase, and clear boxes represent tasks that are more in the foreground and thus tend to organize the field of therapy at a particular time.

The Healing Tasks Model is multilayered and iterative, maintaining a perspective on the whole of the therapeutic journey while attending to a particular element along the way. Importantly, '*all* the tasks are *always* present and being worked with in some fashion' (Kepner 1995: 8, original italics). Kepner's model has four phases of therapy, while most others

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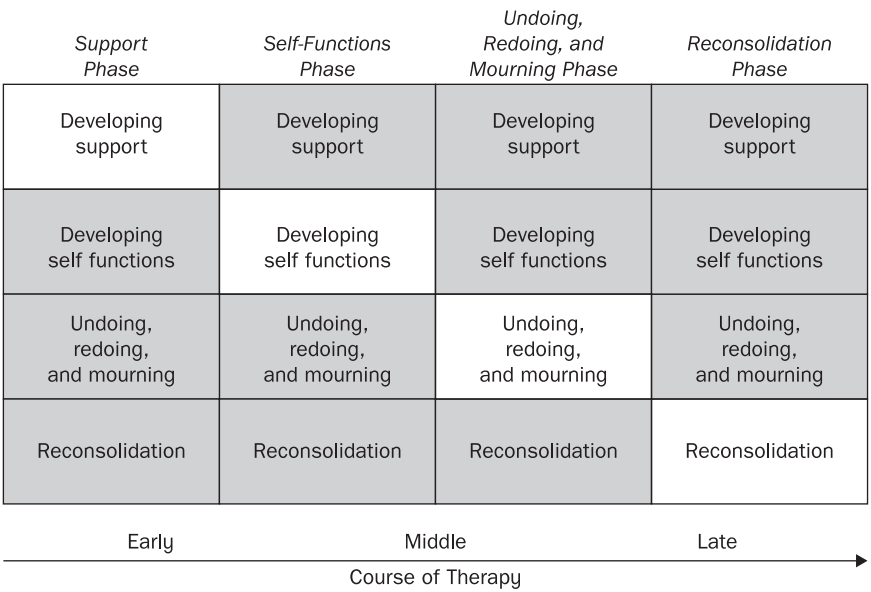

Figure 1.1 Healing Tasks Hologram
(*Source*: Kepner 1995: 8)

have only three; the support and self-functions phases of Kepner's model roughly correspond to the first stabilization phase of other models.

About the book

In the pages that follow, readers will find an enquiry into the compatibility of neuroscience and Gestalt therapy theory, and their clinical application to psychological trauma. The book rests on the three pillars of Gestalt therapy – **phenomenology**, field theory and **dialogue** – and draws on other sources, including trauma research, bodywork and psychoanalysis. The field orientation is voiced by Yontef, who says of Gestalt: 'We have always been an integrating framework . . . we take what we need from the total field' (1993: 258). While integration is to be encouraged, this application to Gestalt could begin to look as incoherent as other approaches. Brownell's more nuanced position is that a *modified* phenomenological, dialogic and field approach can be helpful (2012: 124, my italics), and it is in this spirit that we embrace the insights gained from neuroscience in respect of trauma clients. The intention is to create a coherent approach. We bear in mind that inherent tensions arise from

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integrating approaches with different philosophical foundations. Delisle suggests that integration between modalities should seek compatibility between them 'in such a way as to reduce their weaknesses and maximise their strengths' (2013: 16).

This book is strongly influenced by three main sources relevant to Gestalt. Sensorimotor Psychotherapy in many ways presents the necessary modification to the phenomenological method for trauma clients. Its derivation from Gestalt makes it a particularly compatible approach, and yet there are significant differences (Taylor, 2013). Informed by neurobiology, Sensorimotor Therapy offers a number of theoretical maps that are invaluable in trauma work. Daniel Siegel is an interpersonal neurobiologist who is making a significant contribution to our understanding of the mind. Like Ogden et al., he brings together a range of findings and provides a multi-dimensional perspective on mind, trauma, emotion, regulation and mindfulness. Siegel writes a great deal about **body/mind**, rather than conceptualizing embodiment per se; for him, mind is body. This is implicit in his thinking about whole systems. Philip Bromberg is a relational psychoanalyst who offers important and rich understandings about trauma, focusing mainly on dissociation and the therapy process. Bromberg's wide definition of trauma includes early relational misattunement, unavailability and rupture.

The book has three parts. In the first, some of the foundations of Gestalt therapy are considered in the light of neuroscience and trauma theory. There are some criticisms particularly about the Gestalt understanding of the process of change, and also some ways of augmenting Gestalt practice with trauma victims. The intention is to inspire considered interventions which can enlarge the field of choice for these clients, taking into account the functional limitations as revealed by neuroscience research. A glossary is provided at the end for non-Gestalt readers; the first mention in the text of a term in the glossary is highlighted in bold. The second part focuses exclusively on the main phenomenological features of traumatized individuals, drawing the reader into a deeper understanding of their experience, and how to apply new thinking from neuroscience. Finally, the book brings the reader into the relational heart of trauma, considering the work from the point of view of both therapist and client. This part carries forward some of the thinking laid out earlier in the book, presenting it in a completely new light.

You will find many clinical vignettes throughout the book. To preserve anonymity, the stories about clients are largely fictitious, though based on facts about composite clients. The accounts of spoken and unspoken dialogue are more or less accurate examples capturing actual clinical moments. Because trauma therapy places considerable demands on the therapist, which can cause them also to become ungrounded or dissociated,

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there is also a sequence of experiments and reflection points, which invite therapists and trainees alike to deepen their awareness of process and embodiment. Readers are encouraged to keep a written response to some of the material that is offered.

Finally, a comment on terminology. The word 'victim' is used consistently in favour over the current convention of 'survivor'. 'Victim' too often has a pejorative overtone, whereas in this volume it is intended to convey the suffering of trauma, which 'survivor' does not encompass adequately. A victim is simply someone who has been hurt. There is also a relational aspect to this use of language; when you call someone a survivor you move ahead of where they might feel themselves to be. It would be mistaken to suggest that where there is a victim there is also always a perpetrator. Accidents and natural disasters create victims without there being necessarily either individual or collective perpetrators.

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PART 1
Enlarging the field of choice

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2 Making change possible

For Gestalt therapists the principles of the **Paradoxical Theory of Change** lie at the heart of their existential and relational attitude, suggesting that change occurs only when we accept fully who we are. However, what we learn from neuroscience calls into question the assumptions on which the Paradoxical Theory of Change is based. This chapter looks at these assumptions and reconsiders this theory in the light of certain neurobiological features of trauma clients. Of particular interest is the model known as the Triune Brain, which shows how the fully integrated functioning of the brain and body/mind is compromised by traumatic experiences. This model points in the direction of creating the specific conditions for change that are needed in trauma therapy. A new Integrated Model of Change is introduced which is consistent with Kepner's phased approach to trauma therapy, and from which the conditions for the Paradoxical Theory of Change can later be applied.

Change from the client's point of view

We start, as we should, with the client. Trauma clients arrive at our doorsteps with memories, expectations and fears – or none. Some clients come with a story while others simply experience trauma-related symptoms. There are those whose memory of trauma, including early developmental abuse, is intact, and others who have no comprehension that the difficulties that bring them into therapy are related to something in the past. Many simply seek relief for a particular symptom, such as panic attacks, and do not also connect their nightmares to them, for example. They may seek a return to their 'old self', the state they identified with before the trauma occurred, and for those abused in childhood the question may be more about seeking the self they would have been had their situation been different. In this there is inevitably deep loss. Some trauma clients have

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very minimal expectations for change, while others have idealized and intense longings to be rescued; these polarized expectations reflect the splits that trauma generates. For many, change threatens the adaptations that have been made in the service of survival.

In an over-medicalized field, there are clients who come to therapy expecting to be made better by some means or any; they do not expect to take a collaborative role in their healing. There are trauma clients so terrified of intrusion and the unpredictable that they fear the therapist's interventions; the novel is for certain people a threat and they make every effort to retain control over the process. One of the defining qualities of this client group is that choice is very limited, and this affects their expectations for healing. It is common for trauma clients to have little understanding of what change is possible, the opening to new possibilities of which they are as yet unaware. One client said, 'It doesn't help if you just focus on my experience, I need you to hold the bigger picture too, including a belief in who I can become', unable to do this for herself yet. It was important to be able to meet her in her despair and not to get lost in it.

While for too many clients good trauma therapy is a last resort, they may also be deeply ambivalent about the process. Trauma clients come into therapy driven more by fear than by self-care. They have a terrifying dilemma – the tension between their desperation for relief and their assumption that it will involve a re-living of their suffering. Over-identified with their trauma, they lose sight of who they might become and imagine being immersed in an agony they know they cannot bear. Therapy can therefore come to be perceived with more terror than hope.

Introductory comments

New advances in our understanding of trauma have been informed by neuroscience research and there is a proliferation of new approaches to this subject. It is tempting to look at any one of them as the 'magic bullet'; we want after all to hold out hope for our clients. Belief in a happy ending ties in with cultural denial and avoidance of suffering: make it all better and then the bad thing will go away, be sanitized. As long as there is a solution, the problem doesn't exist in the same way. Often this is our client's fantasy too, on entering therapy. While this book aims to show that there is indeed much hope because change and growth are always possible, and that the most debilitating suffering of post-traumatic difficulties can be avoided, it is also true that individual victims of trauma are sometimes very damaged indeed.

Recovery is never something that we can make assumptions about. So there is a caveat which it is wise to bear in mind – trauma therapy may not

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represent a 'cure' for all; it may simply be enough to offer sufficient support to enable the client to take the next step (L. Perls 1992: 118), which for many is in fact the first step towards breaking out of the vicious cycle of trauma. Trauma therapy is not about goals per se, it is about taking one step at a time and seeing how far the journey takes you. Gestalt therapy values human potential; change and growth are not synonymous because change can be for the worse, but the spirit of potential and growth are implied in this book.

The Paradoxical Theory of Change and trauma

Beisser derived the Paradoxical Theory of Change (1970) as a reflection of the therapeutic principles of Perls and his colleagues, and it encapsulates many classic Gestalt values. It has become a foundational theory of Gestalt psychotherapy, informing its process orientation, relational stance and creativity. The brilliance of the theory lies in its simplicity: change occurs not when the client tries to be other than they are – 'what he "should be" and what he thinks he "is"' (Beisser 1970: 89) – but instead when he enters fully into whatever he is experiencing at the moment. It is for this reason that Gestalt therapy is sometimes referred to as a therapy of the obvious. Being fully oneself, without effort to change, is the essence of Beisser's theory, hence the paradox. The theory rests on the premise of the client being able to 'stand in one place in order to have firm footing to move, and that it is difficult or impossible to move without that footing' (Beisser 1970: 89). The Paradoxical Theory of Change has explicit implications for the way the therapist approaches the therapy, and this will be considered separately in Chapter 10.

The Paradoxical Theory of Change is predicated on a number of assumptions about the client. The list includes the following self-functions: the ability to self-regulate; the ability to make choices; the ability to move forward with fluidity; the ability to participate in healing; the ability to bear pain; the ability to trust in emergent process; the capacity to reflect on, organize and integrate process; the ability to stay with the here-and-now; and the capacity to be available for contact. There is an overarching assumption in Gestalt therapy that the client has everything they need in order to grow. For clients in the aftermath of trauma none of these assumptions holds true, and when the effects of trauma become enduring, few of these assumptions can be relied upon at all times; many of these self-functions will be underdeveloped or restricted.

From a Gestalt perspective growth becomes possible when organismic process is not interfered with, but trauma does interfere massively with vitality and process. Beisser states: 'The Gestalt therapist . . . believes

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that the natural state of man is as a single, whole being – not fragmented into two or more opposing parts. In the natural state, there is constant change based on the dynamic transaction between the self and the environment' (1970: 89).

While accepting this as an ideal and perhaps obvious situation, it has to be understood that this 'natural state' is far from the reality of trauma victims' lives. In trauma this state has been severely interrupted and fragmented, and the self tends to become much more rigid, the fixed gestalts being structurally embodied. Beisser is interested in reversing the pillars of Freudian thinking into processes, and in trauma work this needs to happen at a literal level rather than conceptually. The Paradoxical Theory of Change implies the here-and-now whereas the concerns of the client are stuck in reliving a past that cannot be changed. The cyclical and repetitive nature of trauma is well recognized, while the Paradoxical Theory of Change needs a sense of forward movement to hold true. It implies experience nearness, where trauma clients need to find some distance from their experience. The Paradoxical Theory of Change is therefore somewhat at odds with trauma theory.

There are risks involved with adherence to the Paradoxical Theory of Change with trauma clients. We might suggest for example, that accepting fully that I feel out of control (as many trauma clients do) opens up a sense of control, or at least makes some choices available to me. We might reasonably assume that these choices would be 'top down' (Ogden et al. 2006) decisions about how to restore some functional order to one's life. However, it wouldn't touch the bodily sense of feeling out of control, or address the 'bottom-up' need to be in control particularly of flashbacks, nightmares or other bodily based intrusions which so severely impact the lives of trauma clients. At best, keeping the client's difficulties figural in such a fashion would be unproductive. At worst, sharpening **figures** of distress can trigger a highly dysregulated state, perhaps inducing a reliving of the trauma in a state of utter terror. It is more helpful to gain some sense of being in control in order to fully realize what being out of control is.

Turner et al. warn against revictimization by unscrupulous or poorly trained therapists ([1996] 2007: 540). This not only risks retraumatizing the client, which is highly questionable ethically; it may also result in some act of self-harm, picking a fight or going on a binge following the session. Attention to risk assessment and management issues is a given when working with any trauma client. It is becoming clear that something else needs to happen to restore the client to a more natural state in order for change to take place.

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Other factors in the change process

The origins of Gestalt therapy lie in Fritz Perls' training in psychoanalysis, and while he deviated from many of its principles and practices, he maintained a belief in cathartic or expressive methods as a component of change. We can see this reflected in Beisser's subsequent theory of change, in which being fully oneself may require full expressive range of potentialities. The 'safe emergency' of the therapy setting allows for this, as do traditional creative techniques. Though most Gestalt therapists would agree with the philosophical and existential stance of becoming fully oneself, Gestalt psychotherapy has evolved since 1970 – the year Beisser's theory was published – into a less expressive and more explicitly relational, field-oriented paradigm. This is nothing new, for a clear relational position between therapist and client is espoused by Beisser, in which the therapist declines the role of change agent.

One implication of this is that the therapist should not interfere with the client's natural growth. However, contemporary Gestalt psychotherapy has become considerably more sophisticated and subtle, with threads of both the experiential and the relational creating a fabric of different texture and quality. 'Any approach to change in psychotherapy that does not include both experimental phenomenological awareness work and a caring respectful dialogical attention to the relational contact is not complete' (Yontef 2005: 92). This emphasis on relationship and intersubjectivity begins to align Gestalt with many other therapeutic approaches with more psychodynamic roots.

Stepping outside Gestalt for a moment, but in a way that is wholly compatible with it, we turn to address the issue of relationship as a catalyst for change. The Boston Change Process Study Group comprises eminent psychoanalysts, psychotherapists and researchers who have met over a number of years to consider and deepen their understanding of the nature of change. Their thesis (2010) is founded on the dyadic properties of relationship, and 'moments of meeting' that happen within it. There is little difference between this and the Gestalt therapy notions of the I-Thou and of contact; it is perhaps of little surprise that this group has published in the *International Gestalt Journal* (see Boston Change Process Study Group 2002). Further, the Boston Change Process Study Group identify moments of meeting as moments of change because they create 'state shifts and organismic reorganization' (2010: 7).

The question of concern in trauma therapy is this: how do we meet with someone who is chaotic, fragmented, rigidified, dissociated or otherwise disorganized in order to create such shifts? The Boston Change Process Study Group describe what they term the 'local level', the minutiae of lived

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experience, similar to the Gestalt phenomenological method. For them, change occurs 'in the small, apparently unremarkable moments as well as in the "lit up" moments of more noticeable therapeutic change' (Boston Change Process Study Group 2010: 100). This suggests both the expressive and the relational. However, a relational emphasis on change processes doesn't take account of trust issues in trauma clients, since there is no basis for the relationship in the first instance. Relational participation can be a problem. It was suggested above that clients need to be active participants in their healing, and this is a contradictory position for those who have experienced trauma and who may be passive or overly self-reliant or both. Furthermore, one way of defining trauma is that it is a denial or negation of active autonomous participation, control or choice in life; a result of this is passivity. From a field perspective, relationship needs to be considered as a factor in supporting change, and we will look at some of these dynamics later in the book.

There is a link between self-agency in therapy and hope. If I have a sense that there is something that can be done about a situation, I can have hope for a new outcome. Simply entering therapy evokes a sense of self as agent: 'I can seek help' is a new possibility, even where it is born out of desperation and hopelessness. It is a common expectation that the therapist will 'do' something to 'fix' the problem, especially in a contemporary field where difficulties are medicalized, hope being placed in the 'powerful' other, and not in a belief in one's own capacity for change.

Snyder et al. suggest that a placebo effect may also contribute to change in therapy, which represents 'motivational expectancies for improvement' (2002: 16). Turner et al. suggest the placebo effect in trauma therapy to be as great as 40 per cent ([1996] 2007: 541). A key point which is pertinent to trauma therapy is made by the Boston Change Process Study Group: '*Not every direction that could be co-created would be healing or constructive for the patient*' (2010: 104, my italics). Bearing this in mind, there is a dilemma for the therapist working with trauma: does change come about as a result of the efforts of an expert practitioner or by learning to heal oneself (Levin and Levine 2012: 6)?

The Boston Change Process Study Group writers make a further interesting point that change needs to occur in two separate domains of experience: the declarative, or conscious verbal, domain and the implicit procedural or relational domain (2010: 3). This is of particular relevance to working with trauma, for implicit relational knowing (how one is welcomed in the world for example), integrates emotional, cognitive, relational and behavioural dimensions. What is not stated but needs to be stressed is that the somatic or physiological level is also implicit: 'Implicit memories are best thought of as somatic and affective memory *states* that are not accompanied by an internal sense that something from the past is being remembered' (Ogden et al. 2006: 236, original italics).

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This brings us directly to the territory of trauma clients whose lives are beset by incomprehensible and unbearable implicit knowing, and it is in this dimension that integration is crucial for processing to take place. It is common practice to spend some time reflecting on a novel experience, including Gestalt experiments, as part of 'processing' and assimilating it. Reflection can therefore be seen as a feature of change, a new knowing which completes the **cycle of experience** and allows for integration of unfinished business. Reflection is a useful self-function to develop as it provides a counter to the reactivity of many trauma clients.

Reflection point

Recall a time of personal change in therapy. What was it that helped facilitate this change – was it insight, something your therapist said or did, an experiment, making meaning or connections between different experiences, or something else? What had led up to the change – did you get stuck or blocked in any way or feel some conflict about moving forward? What part in the change did you attribute to your relationship with your therapist? What was your embodied sense of this change and how significant was that? Take some minutes to write about your experience in the present tense, adding some reflections in hindsight.

Neuroscience, trauma and change

The Boston Change Process Study Group (2010: 59) quote Weiss: '[the] "enduring co-ordinations" that constitute the organization of the organism-environment system [rest] on the biological device of specificity'. The specificity in the case of trauma clients is that material which has not been completed and integrated becomes stuck, sedimented and embodied into rigidly fixed gestalts – those unending repetitions of fear, intrusions and avoidance which are so characteristic of trauma. As opposed to this stuckness, Gestalt therapy favours flexibility. Philippson states: 'The paradoxical theory requires that the client has the neurological capacity to move flexibly into new perceptions and relations to the environment' (2012: 90). This flexibility is simply not available to trauma clients and the basis for this is neurological. Neuroscience has changed the 'rules' as to how we make choices, change and grow as human beings. Fortunately, we now understand that the brain is 'a dynamic process undergoing constant development and reconstruction across the lifespan' (Cozolino

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2006: 50), which can be imagined as a process of pruning, maintenance and regrowth (Schore 2003c: 131). Included in our thinking and planning for trauma therapy, herein lies new hope for this group of clients.

A first principle of neuroscience is Hebb's axiom (1949): neurons that fire together wire together. This means that the more we revisit or rehearse a particular situation, thought pattern, behaviour or feeling, the more strongly embedded it will become. Trying to complete the unfinished situation by going over and over the same problem, whether intentionally or not, is only going to reinforce it, hence the risks inherent in working from the Paradoxical Theory of Change. Clients' persistent efforts change nothing, for after trauma the natural fluidity of process has become blocked. However, in trauma therapy it is possible to take advantage of the plasticity of the brain to establish new neural pathways and networks to break out of the unresolved cycle.

One of the main structures of the brain that is implicated in the fear response – part of the primary circuitry concerned with trauma – is the hippocampus, and this is one of the sites in the brain where new nerve cells – neurogenesis – can grow during adulthood (Fogel 2009: 257). Siegel summarizes this process using the acrostic SNAG – *s*timulate *n*euronal *a*ctivity and *g*rowth (2007: 291). *This process appears to require conditions which are stress free, and so points to reducing stress as a precondition.* Neural pathways cannot develop under the original conditions, their growth being dependent on new experience: 'The experience-dependent plasticity of the mind-brain-body becomes key to understanding the possibility of changing minds and the learning that can take place in psychotherapy' (Wilkinson 2010: 2). Neuronal growth is stimulated by attention – where our attention goes so does increased blood supply – which supports the firing of neurons in a way that promotes integration between disparate regions of the brain (Seigel 2007: 291).

The Triune Brain

MacLean's theory of the Triune Brain (1990) is a very useful concept for understanding the regions of the brain that are implicated in trauma. Sometimes misunderstood as a model of brain structures that are anatomically distinct, and criticized for its evolutionary perspective, the theory does nevertheless propose usefully that there are three layers of the brain which operate together to a greater or lesser extent, under different circumstances (see Figure 2.1). The utility of the model for trauma therapy is that the hierarchical layers of the brain have much to tell us about survival mechanisms.

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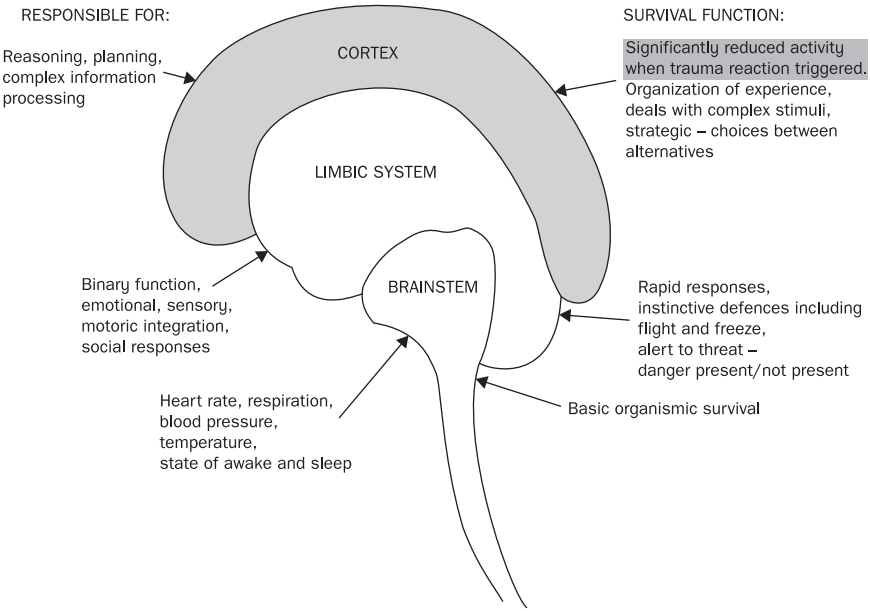
RESPONSIBLE FOR:
Reasoning, planning, complex information processing
CORTEX
SURVIVAL FUNCTION:
Significantly reduced activity when trauma reaction triggered. Organization of experience, deals with complex stimuli, strategic – choices between alternatives
LIMBIC SYSTEM
BRAINSTEM
Binary function, emotional, sensory, motoric integration, social responses
Rapid responses, instinctive defences including flight and freeze, alert to threat – danger present/not present
Heart rate, respiration, blood pressure, temperature, state of awake and sleep
Basic organismic survival

Figure 2.1 The functions of the Triune Brain

At the lowest, most primitive level is the brainstem, leading into the spinal column, concerned with basic physiological functions such as heart rate, blood pressure, respiration and states of sleep and wakefulness. It is very much an on or off structure: when one or more of these functions is damaged by injury or disease, death of the organism will swiftly follow. Sitting atop the brainstem is the limbic system. This level is more flexible, dealing with stimulus responses and sensory, emotional, non-verbal, social, and a range of reflexive defensive processes. Reactions that are driven by the limbic system can flood throughout the body in as little as one twentieth of a microsecond – literally less than the blink of an eye. After all, in situations of danger speed is of the essence. There is much debate about which precise structures constitute the limbic system, but as a functional concept for the seat of survival defences and emotionally charged states it remains useful (LeDoux 2002: 212). Lying over the whole, directly under the skull, is the cortex, largely translating material from the environment and the other two areas of the brain into verbal, reasoned, conscious thought. It is in this area that higher-order planning for defensive action may take place.

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Special functions of the brain

Of course this model is an oversimplified representation of extremely complex specialist functions, none of which is wholly confined to a particular layer or structure of the brain; most functions are spread between areas throughout the brain. There are multiple bidirectional, dynamic, and self-organizing connections between different structures and layers of the brain. Bearing this in mind, it is interesting that much research into the neuroscience of trauma has focused on structures within the limbic system, particularly the amygdala, the hippocampus and the thalamus, and the relationships between them in situations of fear and threat. Numerous studies have revealed that under conditions of threat, there is *increased* activity in these sub-cortical regions and *reduced* activity in the cortical regions of the brain. LeDoux suggests that 'the argument that cognitive processes might involve other circuits, and might function relatively independent of emotional circuits, at least in some circumstances . . . seems correct' (2002: 212). It has been said that *under threat, the cortex simply goes 'off line'* (Ogden et al. 2006: 142; see also van der Kolk [1996] 2007: 233). This has significant implications for therapy with trauma victims.

Furthermore, in situations of chronic trauma, particularly during the stages of early childhood in which the brain matures rapidly, some structures may be unable to develop fully, including the hippocampus and the corpus callosum, the 'bridge' integrating the left and right hemispheres of the brain. Wilkinson (2010: 39) cites research by Teicher et al. (2003) showing as much as a 15–18 per cent reduction in the corpus callosum, with neglect being the strongest experiential factor associated with it. Schore reports that paralimbic areas of the right hemisphere are 'preferentially involved' in the storage of traumatic memories indicating that these are activated from this area (2003a: 259). Once again we see that the brain thrives under the right conditions. 'The ongoing paradigm shift across all the sciences is from conscious, explicit, analytical, verbal, and rational left brain to unconscious, integrative, nonverbal, bodily-based emotional processes of the right brain' (Schore 2008, cited in Wilkinson 2010: 9).

The relational brain

Lest we go too far down a reductionistic unitary path in considering the adaptation of the brain to trauma, let us turn briefly to the relational aspect of brain development. Philippson reminds us that neurological development is relational, as evidenced by the work of Schore, Beebe

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and Lachman, Siegel and others, and he considers that the 'deficits can be worked with in a relational therapy which leads to *physical changes in the functioning* of the client's brain' (2012: 89, my italics). Neuroscience therefore has something to say about who determines the future for trauma clients: 'Mind responds to the changes that occur in the brain as a result of mind-brain-body interactions with another mind-brain-body experience; brain is modified in response to mind, and so on' (Wilkinson 2010: 125).

The here-and-now focus, the phenomenological method and the experimental approach of Gestalt therapy usually offer a client 'a problem that cannot be solved in her habitual way' (Philippson 2005: 14), in order to introduce novel choices and possibilities. Without a neurobiological perspective, the field of choice is narrow; trauma is simply a problem that cannot be solved. Stuckness and failure are familiar problems for therapists working with trauma. Psychotherapeutic concepts of resistance and impasse are challenged by insights from neuroscience. For people who have experienced trauma, there are aspects of their lives that they are no more able to change than walk a tightrope with a broken leg. This is not to say that psychological resistance or impasse are not also possible for these clients as for any others, but that there are also processes over which they have no voluntary control at the outset. They come into therapy without the neurological connectivity to gain control and make the changes they desire. This client group requires something different from our customary ways of thinking about and enabling change.

Creating the conditions for growth

Beisser rather beautifully says that the goal of therapy is to be able to move with the times while maintaining some individual stability (1970). These two functions are precisely the ones that are impossible for trauma clients, who are both stuck in replays of the past and unstable. It is a given in Gestalt therapy that people are living organisms constantly in process, adapting and emerging in response to the internal and external field. Change is *always* happening, even if it is so slow that it appears static. Parlett's Principle of Contemporaneity (1991) shows that there will always be a degree of newness in each reliving of traumatic experience: this reliving is in this unrepeatable moment.

However, Yontef, aware of risk and unproductive therapy, raises a crucial issue:

> The central question is not whether there will be change but whether human change will be towards growth or deterioration . . . [how] do individuals and their societies, including psychotherapists,

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> influence and support change in the direction of healing, growth and wholeness, and how do they interfere with healing, growth and wholeness – or even precipitate deterioration?
>
> (2005: 82)

It is necessary to find ways of loosening the fixed gestalts in trauma without doing damage. When '[the] person's brain cannot support different ways of being' (Philippson 2005: 16), the risk of deterioration is increased if we fail to attend to creating the right conditions within the body/mind for the emergence of novelty. Philippson states further: 'The paradoxical theory cannot be simply applied in situations where the client is sensorily out of contact with where she is' (2005: 14). The need to bring the client more into sensory contact with "where she is" is not at variance with Gestalt therapy values; the issue for trauma clients is rather about what we do and how we support their ability to be in contact. Stratford and Braillier's metaphor of glue and solvent in therapy (1979) is relevant here, 'what specific glue? and 'precisely how much solvent? being key questions. Clients need both fluidity and stability.

Bearing in mind that 'The mechanisms that bring about change in psychotherapy are incompletely understood, at best' (Boston Change Process Study Group 2010: 38), and that 'traumatic threats to survival that produce extreme fear-based memories are more recalcitrant to change' (p. 187), we turn now to consider some of the possibilities for trauma therapy that are opened up in the light of neuroscience. The glue and the solvent of trauma therapy need to include the building of self-functions that address some of the presumed neurological deficits. Earlier, a list of some of the self-functions upon which the Paradoxical Theory of Change is predicated was presented, all of them deficits for clients with complex or developmental trauma. Trauma therapists need to embrace an *intentionality* of change as an active interference with the sedimented natural process which otherwise leads inexorably towards deterioration: 'the sometimes very rational decision in favor of particular changes' (Fuhr 2005: 83). Much of the evidence for effective trauma therapy points towards working in particular ways with the body so as to facilitate the emergence of these self-functions.

Trauma clients need to be able to reorganize their fragmented, dissociated and implicit experience into a coherent and unified **gestalt**. To achieve fluidity and stability requires the resolution of polarized splits in functioning and increased integrative capacity. Problems concerning integration for trauma clients have already been touched on throughout this chapter. 'Without adequate integrative capacity, clients cannot maintain regulated arousal, resolve their memories, or lead productive satisfying lives' (Ogden et al. 2006: 182). It is the failure to integrate traumatic

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experience that is the substance of the unfinished business of victims' ongoing problems, and therapists need to use particular interventions to enable integration to take place. Importantly, if the disintegrated process is not reversed the sense of trauma for the client will worsen. Kepner rightly points out the central role of the *embodied* self in the process of integration (1987: 10). It is only on this level that someone can fully comprehend their experience as their subjective truth, even in the absence of words. 'Emotion and the body are at the irreducible core of experience: they are not merely there to help out with cognition' (McGilchrist 2010: 185). Integration involves 'both differentiating and linking the separate components of internal experience and external events in order to create meaningful connections among them . . . This capacity facilitates the maintenance of an internal locus of control over one's body, emotions and thoughts' (Odgen et al. 2006: 182–3). The implicit can become explicit through the body.

Integration of splits is therefore a further goal in trauma therapy. A dramatic split in brain function is that between cortical and sub-cortical regions during traumatic episodes. '[The] goal . . . is to integrate and balance the various cortical and subcortical, left and right hemisphere, processing networks. This process requires a decrease in anxiety from high to moderate levels. High levels of emotion block thinking, whereas moderate levels can result in cognition *combined* with emotion' (Cozolino 2002: 58, my italics). Anxiety and imbalance are prime consequences of dis-integration. There is therefore much interest in those interventions that reduce anxiety and thus promote the strengthening of neural linkage between primitive responses and higher-order functioning. This requires more than an anxiety management approach. Goldstein observes that 'the new order appears to arise out of the system's own internal resources when the right conditions are met rather than being imposed by external forces or factors' (2007: 111), which concords with neurologically informed therapy. The body knows how to heal itself under the right conditions.

Sensorimotor Therapy sees the body as a 'primary avenue in processing trauma' (Ogden et al. 2006: 166), thereby creating the necessary internal resources and a sense of coherence. Fogel comments that

> We can't make embodied self awareness happen but we can create the conditions that best encourage its growth . . . the more we actively practice opportunities for embodied self awareness to emerge . . . the more we have the ability to stay longer in the subjective emotional present and the ability to choose to tune into particular sensations in particular parts of the body . . . neural learning is reflected in physiological changes in the nerve cells and their connections.
>
> (2009: 61)

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Ogden et al. recommend a blend of top-down and bottom-up approaches to working with implicit memory. Top-down cognitive interventions are employed to foster regulation through meaning-making and observation by means of phenomenological tracking and are cortically mediated. In this mode language and story are 'entry points'. Bottom-up interventions start with the body, using sensation and movement to support emotional regulation and the processing of memory. 'Through bottom-up interventions, a shift in the somatic sense of self in turn affects the linguistic sense of self' (2006: 166).

'More directly associated with overall body processing sensorimotor processing includes physical changes in response to sensory input; the fixed action patterns seen in defenses; changes in breathing and muscular tone; and autonomic nervous system activation' (Ogden et al. 2006: 7). There are clear similarities here with the undoing of fixed somatic gestalts in Gestalt body process, though the intention behind the interventions is focused on processing and integration rather than on awareness. It is possible, however, to place too much emphasis on either one of these modes of working, to the detriment of integration. A useful Sensorimotor question is therefore to enquire of clients 'What goes with that thought/feeling/sensation?', which can link thoughts to somatic experience or vice versa.

Clinical vignette

Sarah, for example, had been brutally raped, but for many years saw it simply as unwanted sex. This was a defensive and dissociated fixed gestalt that carried with it much self-blame for not having said 'No'. She needed to feel the insult and violation in her nervous system in order to own it for herself as rape – being fully herself as the Paradoxical Theory of Change proposes. As a precondition for her acceptance of the unbearable knowledge of her rape, her capacity to tolerate the strong emotions and sensations that went with it needed to be strengthened. This was achieved over many months of detailed attention to building an internal sense of safety, repeatedly directing Sarah away from her almost irresistible pull towards traumatic material – the figures she was not yet able to support. By learning to notice and identify body sensations and their accompanying thoughts without judgement Sarah was able to make new meaning of them; through learning to track the flow of sensory experience she gained a sense of continuity.

Over time Sarah learnt to regulate herself better and became able to stay more present. All this was offered through a respectful, dialogic and phenomenological focus, with interest and graded presence on my

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part as therapist, an experimental stance of discovering together what best supported Sarah. At this early stage of therapy I had a clear goal in mind at all times, while maintaining a degree of ***creative indifference*** *about how we reached it. Together we reflected a good deal on what was going on; there is nothing new in this for Gestalt therapists but I kept in mind that this was needed to allow for reorganization of Sarah's experience. Although there was much 'technique' in this work, I knew that Sarah would be quick to spot any interventions that were based only on technique; she needed authentic relating from me as her therapist.*

It was only once she had reliably learnt to bear the pain – Beisser's condition of stability – that Sarah could finally say, 'What that man did to me was rape' and find her sense of 'No' in her body. This helped to reorganize her self-concept to include rape, making new meaning. Thus she could integrate her experience without dissociating, and the Paradoxical Theory of Change could apply. Of course neither Sarah nor I ever knew what changes may, or may not, have taken place in her brain, and these were never part of my conscious thinking in our work. The very fact that I was standing on different philosophical and theoretical ground may have been enough to reorganize the field towards change. I was guided, however, by my understanding of the processes and principles of trauma theory, and always took my lead from phenomenological cues in Sarah and myself.

Towards an Integrated Model of Change

There is much of value to therapists in the Paradoxical Theory of Change. It is a fundamental philosophical position, a spirit that one would not abandon lightly. However, it is very much a theory of its time, in accordance with the early view that Gestalt therapy would be effective for all client groups. Kepner's Healing Tasks (1995) looked at the specific issue of childhood trauma, and offered a phased approach to therapy. Within these phases Kepner identified a number of tasks, including the development of self-functions, that need to be fulfilled in order for recovery to take place. This is not entirely consistent with the essence of the Paradoxical Theory of Change, but *is* consistent with good trauma practice even though it was written before the impact of neuroscience had registered in the field.

Philippson is a contemporary Gestalt therapist who questions the usefulness of the Paradoxical Theory of Change for some clients, including those who have experienced trauma: 'It is only once the new functioning, allowing caring and being cared for, has "bedded in" neurologically that the paradoxical theory can function' (2012: 90). He continues as perhaps

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many – too many – experienced therapists could: 'In the past I have been guilty of trying to help create the conditions in the moment which would support growth, not knowing that the kind of relational growth I was trying to support was not possible for them at their present level of neurological functioning' (Philippson 2012: 90). This is a cautionary experience, one which therapists would do well to take note of and learn from. Philippson considers that we need something more subtle than keeping our clients within familiar responses (2005: 13), and a neurophysiological perspective on trauma supports this view.

This subtlety can be found both in certain qualities of the therapeutic relationship (see Chapter 10) and in close attention to Kepner's phases. In particular we are interested in the early stages of Kepner's model, the support and self-functions stages. It is here that the Gestalt trauma therapist chooses deliberately to interfere with the dysfunctional processes that have caused the blocked completion of unfinished business, and here that they take a consciously different relational stance. These phases lay the neurological 'ground' for the processing and moving through of the trauma which take place in Kepner's undoing, redoing and mourning and final reconsolidation stages, which is where the Paradoxical Theory of Change can come finally into its own.

Philippson argues for putting in place 'the prerequisites for the Paradoxical Theory of Change' (2009: 137) for some clients who lack the neurological capacity to self-regulate. What is being proposed therefore is a staged model of change for trauma work: an Integrated Model of Change. This can be expressed thus: *change happens under the optimal conditions in which one can be fully oneself.* In this case, the prerequisite is a preliminary phase of more directed and goal-oriented work, from which the Paradoxical Theory of Change can later emerge. During the preliminary phase the therapist never loses sight of the Theory; it is always an undercurrent, never trying to force change, allowing it to wait in the wings until it can come into its own. There may be goals towards which one directs the work, but growth is never linear: it is a 'trial-by-error process of moving in the general direction of goals' (Boston Change Process Study Group 2010: 9) in line with the hologrammatic perspective of Kepner's model. Thus the therapist is not being coercive, not seeking 'to change' the client in a disempowering manner, simply because 'the best we can do is to meet the other' (Lichtenberg 2012: 181).

We start where the client is, meeting their unified field, their experience of trauma and its aftermath, and in a spirit of holisim, meeting their neurological challenges with attention, understanding and compassion. 'Where the client is' calls for more direction, more regulation and containment, more engagement with present reality. Yontef says: 'The issue for me is whether goal-directed and planned change is done from a phenomenological and

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dialogic perspective consistent with the Paradoxical Theory of Change – or is merely behavior modification based on a person's self-rejection' (2005: 83). This work is both attitudinal and intentional; some subtlety on the part of the therapist is needed to strike a balance that *includes* the attitudinal stance and methodology of the Paradoxical Theory of Change alongside the intention to support particular changes. It is perhaps this attitudinal and intentional shift that most characterizes the change process for trauma that we need to embrace. Beisser tells us that the client needs to have a firm footing to change, and that it is 'difficult or impossible to move without that footing'; for trauma clients our model of change must first establish that footing.

Summary

Trauma clients often have polarized expectations for change, on the one hand limited by a failure of imagination for what they can become, and on the other, an unrealistic expectation for rescue by the therapist. They also enter therapy with many fears that their suffering will continue or worsen, or that they will discover that they can never find relief and healing. Sadly, it is true that some trauma clients bear deep wounds and their healing potential is limited by some of the constraints of therapy – time, money and boundaries, among other factors. And for many there is still hope that with new approaches to therapy satisfactory and transformational change can take place.

The Gestalt therapy view of change is based on Beisser's Paradoxical Theory of Change, in which it is stated that 'Change occurs when one becomes what he is, not when he tries to become what he is not' (1970: 88). This theory encompasses a number of core Gestalt principles, and is predicated on a number of assumptions about the client's inherent capacities, which can be summed up as the ability to make choices: **response-ability** in the here-and-now. However, for trauma clients the level of choice is impacted greatly by the involuntary neurological processes that maintain the cyclical trauma response, and there is a risk that by staying with these familiar responses the client will not recover, and at worst will be re-traumatized. There is a growing awareness in Gestalt that something more than the Paradoxical Theory of Change is needed to facilitate healing for trauma clients. Beyond the Theory, change can be influenced through a number of different factors, which include expressive techniques, relationship and hope. For trauma clients it is the neurological basis of change that is the most necessary to bear in mind.

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There are two principal factors governing brain processes which need to be understood and taken into account in relation to trauma. The first is the phenomenon of neural plasticity, which shows that the brain is capable of development throughout the lifespan, by means of pruning, shaping and growth of new neural pathways. Repair of brain structures that have not developed fully after early trauma has been shown to take place after appropriate therapy. This opens up the possibility that the fixed gestalts of trauma can be loosened and choices made available. The second factor is related to disconnection in the architecture of the brain, presented as a hierarchical layering from primitive sub-cortical structures to higher-order cortical functions, all of which have a role to play in survival under threat.

This is represented by MacLean's theory of the Triune Brain. Neuroimaging techniques have demonstrated that the cortical areas of the brain are less active when traumatic memories are activated, the responses being driven by sub-cortical areas known as the limbic system. It is clear that interventions that increase the growth and integrative capacity of the brain are necessary in trauma therapy. Taking a neurobiological perspective of the brain and its capacities sheds new light on the issues of resistance and impasse in therapy, allowing for a more compassionate stance.

The repair of the brain, which supports change and the processing of the unfinished business of trauma, can only happen under the right conditions. This includes enhancing the integrative capacity of the client by means of both top-down and bottom-up interventions (Ogden et al. 2006), which allow the client to differentiate and distinguish a range of elements of their experience, creating a more unified gestalt. The role of the body is therefore central in bringing about a more integrated experiential field, and trauma therapy cannot afford to ignore this. Something beyond the Paradoxical Theory of Change is needed, which includes the setting of some goals for therapy and a more directive stance on the part of the therapist. In line with the stages of Kepner's Healing Tasks Model (1995) it is proposed that a preliminary stage of change called the Integrated Model of Change be adopted. This model supports the neurological make-up of the client and sets the scene for the Paradoxical Theory of Change to operate when the client is ready to process their trauma. At the heart of effective trauma therapy lies a shift in attention towards particular figures and an intention to promote the integrative capacity of the brain.

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3 The organization of parts and wholes

This chapter explores the interplay of foreground and background known as the process of figure and ground formation, which is of interest in Gestalt. We pay attention to those aspects of our lives that most demand it, and let other aspects of our experience fall into the background. These are among the ways in which we organize and make meaning of our experiences. We are going to take a look at how this is of relevance to trauma victims whose attention is often consumed by managing the symptoms of PTSD – the trauma figures. Very often, the experience of trauma leads to a polarized, and therefore unbalanced, view of themselves or the world, and this restricts possibilities for growth and choices, and adjustments to the field reflect this.

Complexity theory sheds light on particular polarities in stressed systems, and opens up new possibilities for conceptualizing the work of trauma therapy, and we will be linking this with Gestalt theory principles. In order to help trauma clients we need to pay more attention to the structure of the ground, enabling a wider and more nuanced perspective on their experience. The chapter concludes by presenting practical ways of building a repertoire of resources thereby widening the field of choice.

A metaphor for the work

Recently my efforts to write were becoming clogged up – I felt it not only in my thinking but also in my chest, back and lungs. I decided to go for a walk, and needing space and horizons I drove to the nearby downs. It was brisk, bright midwinter afternoon. I gazed out over the landscape, the sweep and curl of hills reaching into the distance. I was aware of the sharp contrasts of dark trees and the glare of the low sun which impeded my vision. When I shielded my eyes from it I was able to make out the detail in a stand of trees about half a mile away, the quality of sunlight on the field beyond it and even the splashes of light breaking between the trees.

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It occurred to me that this was a good metaphor for trauma therapy, that when we take the glare off the trauma we can see more clearly the detail of the whole picture and new meanings and possibilities emerge.

Orienting to trauma

We all tend to organize our lives automatically around our different dominant needs and interests. Self-organization may be goal directed, such as training to become a therapist, but we also have ways of organizing our experience according to psychological needs, such as for intimacy or approval. When we perceive our lives to be endangered, we instinctively organize our behaviour for optimal survival, which is pertinent to our thinking about trauma victims. The original use of the word 'sensorimotor' was coined by Piaget in 1936 to describe the increasing organization of movement in infants, from the involuntary and accidental to the deliberate and purposeful.

These multiple layers of self-organization are not discrete: 'Human beings as living systems *combine* the organizational coherence of an ecological organization, i.e., the environment context, with a biological organization and with a psychological organization' (Sander 1991, cited in Boston Change Process Study Group 2010: 59, my italics). The different ways in which we organize our experience are sometimes out of awareness or implicit, and are dependent on the choices available to us. At each level of organization there is a search for wholeness and fullness of experience of self in relation to the environment.

Gestalt therapists understand this organization in relation to the satisfaction of dominant needs and interests as the basis for gestalt formation. One closely approximate way of translating the word 'gestalt' is as a 'meaningful organized whole' (Perls et al. [1951] 1998: ix). This is a rich concept embracing vitality, fluidity and growth. Importantly the process of making dynamic and meaningful wholes is often interrupted as the opportunity for their realization becomes limited for a myriad of possible reasons. We will consider this in relation to trauma shortly, but for now it is helpful to comment on the differentiating and unifying properties of the process of forming gestalts (Perls et al. [1951] 1998: 63). It is when we are able to distinguish clear gestalts that our organization of experience becomes increasingly coherent or unified.

Sympathetic with Gestalt theory, the concept of coherence of organization is also central to Sander's thinking, and he sees increasing coherence of psychological organization as a central overarching goal of development. For Sander, increased coherence implies an increased inclusiveness of organization, so that more parts are integrated in more

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complex and adaptive ways into an overall wholeness (2000). One way we can understand this increased coherence is as a reorganization from insecure to secure attachment (see Chapter 13).

The ways we organize ourselves are related to how we orient ourselves in the world (Perls et al. [1951] 1998: 73) in line with our prior experiences, perceptions and the meanings that we make of them. It may be relevant that Perls himself had a difficult childhood and a bullying and volatile father (Clarkson and Mackewn 1993: 2) and had to leave his homeland in a hurry as a political and Jewish refugee. These prior experiences may have informed his interest in unfinished business and orientation to the completion of gestalts. This orientation is particularly relevant to understanding trauma victims, perhaps like Perls, whose reactions to certain stimuli are organized according to meanings predetermined by their traumatic experience (Kepner 1995: 96). For example, the sound of screeching tyres may denote a very specific interpretation for someone who has been involved in a serious motor accident, and their behavioural, emotional and physiological responses will be shaped by it. Trauma victims tend to organize themselves in very fixed ways around trauma because their dominant need is to restore organismic equilibrium. This organization is what is known as the forming of fixed gestalts, as opposed to the free-flowing quality of emergent experience. Trauma is thus an overarching organizing principle in the lives of victims, of which there is a subset of fear, helplessness, disconnection and shame, which are the subjects of Part 2 of this book.

Trauma figure, trauma ground – field, self and other

Imagine standing before a large canvas in a gallery: you take in the whole and then begin to follow your attention to successive details of the image – figures, marks, objects, colour, texture – according to your personal interest; you stand back and take in the organization of the whole. At the same time you have emotions and thoughts and make associations and meanings from the experience, an ever-shifting interplay of figures emerging and receding from the ground. The figures you select for attention and the meanings you make of them in relation to the whole are entirely subjective. You will be drawn for similarly subjective reasons to some images in the gallery rather than to others which you may barely glance at. Theory of figure and ground relates therefore to which parts of our experience or environment we pay attention. It is also concerned with perception and meaning because we make more meaning of those parts we focus on and virtually discard those we do not. This is a key point in making sense of the trauma reactions we meet in our clients.

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In classic Gestalt thinking, figures of interest emerge from and recede into an undifferentiated ground, like the relationship between a wave and water. Gestalt therapists are most interested in the particular ways in which figure and ground relate to one another and are organized. In the words of Perls et al., 'Energy is released for figure-formation when the chaotic environmental parts "meet" an instinctual excitation, define and transform it, and are themselves destroyed and transformed. Mounting excitement is the progressive leaving behind of the ground' ([1951] 1998: 411). The model known as the cycle of experience traces the mounting excitement of figure formation through a number of stages, as well as the subsiding of excitement as the figure recedes (see Figure 3.1). This cycle has been developed and revised by a number of writers (e.g. Zinker 1977; Wheeler [1991] 1998; Mackewn 1997).

In a healthy process the relationship between a strong, clear figure and its ground is constantly shifting and dynamic; when the process functions less well, figures are considered to be weak, stale or lacking energy. Yontef discusses further difficulties with figure formation that we can apply to trauma clients: 'Sometimes what is felt or needed is not allowed to become figural at all; sometimes it becomes figural only fleetingly, with the figure changing too rapidly for real insight to develop or activate new

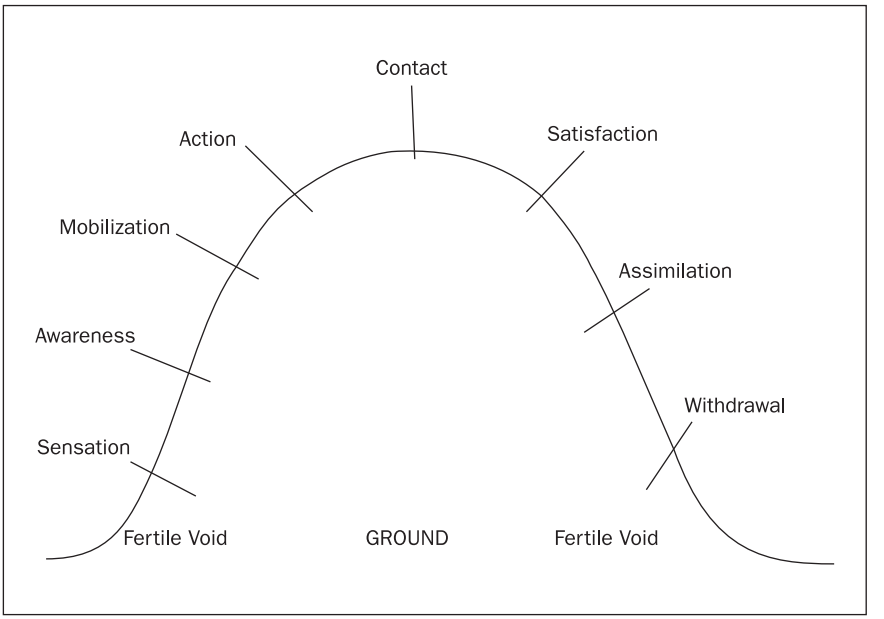

Figure 3.1 The cycle of experience

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behavior; and sometimes a figure is kept in awareness and not allowed to recede to allow subsequent needed figures to emerge' (2005: 90).

Set against this original formulation of Gestalt theory, Wheeler has postulated that the practice of Gestalt therapy is too figure bound, stating that this model depicts human life as 'impulsive, episodic, socially isolated, lacking in temporal continuity and overall organization' (1998: 86). Taken from a field perspective, the impulses and excitements which we seek to promote can only be seen in relation to the ground, the two being indivisible (p. 87). With his revision of the theory, Wheeler produced a more coherent framework and heralded the shift in emphasis from an individualistic paradigm to a system, dyadic or relational one. An implication of this is that we need to pay more attention to structure of the ground, and this thinking is slowly gaining acceptance (Stawman 2011: 12).

It is characteristic of clients who have experienced trauma to have difficulties with figure formation. Generally these fall into one of two predominant styles. There is the client who with a sense of urgency brings to our attention a number of rapidly changing figures within a single session. None is well supported; each feels dense and demanding to both client and therapist. Rapid sequences of figures do not permit attention to the early stages of sensation and awareness, nor to the later stages of **assimilation**, satisfaction and withdrawal, as though the curve of the cycle is too steep. This client's figures are undifferentiated from one another. The second style is the client whose figure formation is so vague as to feel almost absent; they do not know what they want to work on, what is of interest and importance to them. For this client the curve of the cycle is too shallow and remains undifferentiated from the ground. Perhaps they have learnt to defer to the dominant needs of others and will do so again with you. One client commented wryly: 'Perhaps we need to work on me knowing what to work on'. In either of these styles, there is little capacity to distinguish needs, to allow emergence of spontaneity, or to bring appropriate energy to bear in the service of healthy satisfaction of needs. In addition, each style will have a physiological correlate, likely related to their trauma history.

Paradoxically, the problem for trauma clients seems to be that their experience is everything that Wheeler suggested is wrong when we emphasize figure, namely: impulsive, episodic, socially isolated, lacking in temporal continuity and overall organization. Such is the impact of trauma that victims become preoccupied with trauma-related figures which being ruminative and stagnant do not emerge with freshness and spontaneity from the ground. Change cannot occur in the usual ways for these clients because of this preoccupation with symptoms which result in the recursive reliving of the trauma. This can be accounted for in two ways. First there is a need to complete the unfinished business – to make whole

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– which is both biologically and psychologically driven, causing clients to 'rework' the figure; and second, intrusions of flashbacks, nightmares and somatic symptoms are interpreted as indicating the ongoing presence of threat. This means that trauma victims pay very particular and often exclusive attention to those parts of the field that are trauma related.

According to Kepner, '[m]uch of the survivor's reaction and experience will be both theoretically and experientially groundless' (1995: 94). While the spirit of this statement carries the essence of the experience, it no longer holds accurately in the light of Wheeler's proposition. In so far as figure cannot be separated from ground it is a misnomer to suggest that a figure can be 'groundless'; rather it is the quality and the content of the ground that define the problem. Having said this, it is clear that trauma does radically change the ground from which the figures arise. Trauma-related figures are problems that cannot be solved by attending to the figures; the recursive nature of the client's attempts to do so have failed.

In DSM-IV, the diagnostic criteria for PTSD include the following: hypervigilance; avoidance; increased arousal; intense distress; restricted range of affect; feeling of detachment or estrangement from others; and intrusions of thoughts, flashbacks and nightmares among others (American Psychiatric Association 2000: 468). These become the heightened figures which are symbolized in the experiential world of the trauma victim, frozen in time, or fixed in relation to the field which in turn is experienced as dangerous and potentially traumatic. The ground may give rise to fairly fixed figures in trauma (Cleveland Consulting Group, see website). Trauma is thus a devastating reconfiguration in the relationship between figure and ground.

Ground and field are not the same. Ground is more a phenomenological condition, formless and unbounded (Polster and Polster 1973: 30) which contains aspects of the field, both historical and contemporary. 'The ground consists of traces of experience, history and physiology contained in larger, deeper grooves out of which lively figures spring forth' (Melnick and Nevis 1997: 98). The Polsters comment that the main function of the ground 'is to provide a context which affords depth for the perception of the figure, giving it perspective but commanding little independent interest' (1973: 30). When traumatic experiences provide the context for the emerging figure the victim's experiential world is restricted and terrifying.

We therefore need to question whether the statement that the ground is of 'little independent interest' is correct. Kepner gives the all too common example of a client pushing to tell their story even when deteriorating (1995: 98), there being insufficient ground for a more supported figure. One client came into therapy having been retraumatized in hospital, including by the use of ECT, physical restraint and being humiliated for

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her attempts to make herself feel safe. She had been told that therapy had to make things worse before she could get better. With these historical fragments and introjects forming the ground of her experience, we needed to build a radically different context within which to work. According to Melnick and Nevis, 'Th[e] ground must ultimately be affected if a person is to experience a more permanent change' (1997: 98).

Creative adjustments

We develop new figures to enable us to deal with the emerging dominant needs, interests and challenges that life presents us with; these are new ways of making meaning which are called **creative adjustments**. Creative adjustments organize our experience in the ways that are the best we can manage, in response to environmental demands, forming patterns, preferences and biases in particular directions. These adjustments are creative not because they are necessarily inspired – though they may be – but because they are ways of adapting our ways of being and therefore our self; Perls et al. consider that the self is the system of creative adjustments ([1951] 1998: 247). Possibilities either expand or contract in response to a new perception of external 'reality', and it is this process of development which is creative.

For trauma victims, some of the typical adjustments that are necessary are extraordinarily creative, as in the case of dissociation, while others may appear to be self-destructive, such as self-harm. To these extents, creative adjustments may come at a considerable price. Creative adjustments emerge in a world in which choices are severely restricted, and consistent with Gestalt values, it is imperative to honour them as the very best that the victim could do, under seriously compromised conditions. Some trauma clients experience unbearable levels of shame for the adjustments they have had to make, and find it difficult to understand and honour their creativity. When a creative adjustment is honoured an opportunity for a new pattern to emerge is opened up, even if the new way isn't immediately available. These also represent hard-earned ways of managing which trauma clients may not relinquish easily because they have helped them survive in the past, and therapist and client need to come to a shared understanding of the subjective meaning and function of a variety of creative adjustments.

The diagnostic features of PTSD given above can all be viewed as creative adjustments. We can then understand some creative adjustments as symptoms that describe the problems that trauma victims encounter. Trauma theory gives us a context for better understanding these symptoms. Self-regulation is a primary need that is served by making creative

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adjustments. While this is true for anyone in any situation, it is a particularly urgent need for trauma victims, which we will look at in depth in the next chapter.

Take the case of hypervigilance, for example. One reason that traumatic events have the impact they do is that they are originally unanticipated, and there is a shock value. A common response to this is then to remain on constant alert for further possible traumas, in order to mitigate the potential for shock and to maximize the chances of dealing with a threatening situation differently. The regulating function of this creative adjustment is clear, as is the cost for those whose energy is spent scanning the field for threats that don't exist and who may even develop insomnia as the price for staying alert. A further cost is that the regulation achieved is not the result of a fluid and spontaneous process of figure formation and destruction leading to a coherent organization of the whole. We could call this a pseudo-regulation, the best available at the time, because it doesn't satisfy a physiological level of regulation. True **organismic self-regulation** is 'based on acknowledging the complete array of sensory, mental and emotional data concerning both one's internal needs and the needs of the environment, and also the internal and environmental resources' (Yontef 1993: 214). While this will in an ideal situation allow for integration and assimilation, in the case of hypervigilance attention is only given to a limited part of the available information and does not result in an organized whole.

Creative adjustments are part of the complex structure of the ground which influence those parts of the field we pay more or less attention to. Thus they inform our personal biases, prejudices, obsessions and assumptions. They colour our emotional range and tone, our relational style and **contact functions** and the meanings we make of all of these. They also form a part of our physical being – the literal stance we take, the ways we move and our particular preferences for physicality. The biological organism adapts too in response to trauma, engaging particular systems in the brain and nervous system in preference to others, and with the involvement of certain neurochemicals. At this invisible level these adaptations also become chronic, part of the make-up of the individual.

These interwoven dimensions of self-organization are not necessarily conscious or known to us unless we have the benefit of exploring them in therapy. Kepner states that 'A person's body structure is a total of the person's organismic adaptations to life' (1987: 49) and thus has much to tell us about the subjective experience of trauma which is of interest. When we, as therapists, focus on trauma, there are multiple other possible perspectives and presenting issues that we choose to ignore; they recede into the background. Exactly the same principle applies to our clients whose attention, even if they don't make the connections, is on

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trauma, and who thereby exclude other choices and possibilities from their awareness.

Reflection point

Take some time to be open to an aspect of your physical experience, uncritically and with openness and curiosity. Use a mirror to help you, or ask a friend to support this exploration by showing you or giving you feedback. You might for instance be interested in the carriage of your head and its relationship to your neck, shoulders and the rest of your body. Or you may prefer to look at some wider features of how you hold yourself or move. As you become aware, consider the following: 'How did I learn to organize my physicality like this? How does it reflect my story? In what ways does it make sense to me to be in the world in this way? How does it support me to regulate myself according to my individual needs and interests? What meaning do I make of this?'

Spend some time writing your reflections on this experience as well as your answers to these questions. Remember that these adaptations have served you well in the past, and that you do not have to do anything to change them now. It is particularly important that you do not try to impose any kind of change on yourself; try to accept that whatever you are aware of is fine as it is.

Polarities, balance and holism

In ideal circumstances, all parts of the organism are in balance. Organismic self-regulation leads to integrating parts with one another and into a whole that encompasses the parts (Yontef 1993: 148). A simple representation of this is the familiar yin-yang symbol (Figure 3.2). The maxim that 'the whole is more than the sum of the parts' designates the new organization of the parts when they are integrated and coherence is achieved.

The principle of polarities means that everything has its opposite and equal, and that none could exist without the other. 'Day' is meaningless without its polar opposite of 'night', the personal requires the collective, and hope is irrelevant without the possibility of despair. All manner of qualities, functions and experiences of human existence can be viewed in this way. But in no case are these extremes set in opposition, for there are many shades between the two, such as dawn and dusk as stages along a continuum between day and night. A fluidity of movement along a

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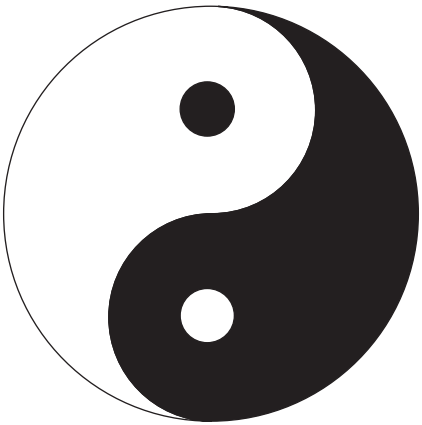

Figure 3.2 Yin and yang – perfect balance

continuum suggests that nothing is fixed and the individual is in a state of healthy process, with a maximal range of possibilities open to them. Joyce and Sills observe that '[e]ach individual is a never-ending sequence of polarities' (2010: 126), adding 'all parts of a continuum are potentially necessary' (p. 127).

We naturally tend towards certain polarities and eschew others. For example, many people find it difficult to accept that their kindness can only exist against a ground of cruelty, and will likely disown this polarity. Joyce and Sills suggest that some undesirable qualities are distortions of natural abilities (2010: 127). Thus cruelty could be a distortion of the ability to defend oneself or to experience personal power and thereby restore regulation. Generally, polarities that are disowned are for one reason or another seen as unacceptable.

There is, however, an inherent contradiction in the case of trauma clients whose biological functioning leads them solely towards polarities representing the perception of threat. Kepner considers that by disowning some polarities the trauma victim is able to preserve some sense of self-cohesiveness. In the case of interpersonal trauma, the self is defined in terms of reactions to either being unlike the perpetrator or identifying with them (1995: 97), which leads to conclusions perhaps that one must never be weak, or must always find fault. Further, for these traumatized clients, it is often the body that becomes alienated from the sense of self, with implicit disowning of contact functions (Kepner 1987: 51). There is a disunity of body self, which for Kepner indicates that polarities of the self are rooted in bodily feeling as well as in other dimensions (p. 27). Polarities

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exist in the body, such as inhaling and exhaling, freezing or collapsing or contraction and expansion. In traumatized clients, polarities tend to become fixed and extreme.

Splitting is a complicated process in psychoanalytic terms, but Gestalt writers have an accessible take on the issue. Philippson sees it as an alternative to choosing (2009: 99–100), perhaps between two seemingly irreconcilable polarities. For Yontef, splitting means being in touch with one part of the field and out of touch with another, perhaps polar opposites, and sometimes reversing this (1993: 262). Either way, splitting is a phenomenon common to trauma victims. Indeed, it is a necessary adaptation to overwhelming threat, because not all aspects of the field can be contained appropriately. The pull in some trauma clients to one polarity of their experience is almost magnetic, a force which is not always possible to resist.

It is tempting and sometimes harmful for therapists to align with a dichotomized process, for in so doing we too focus on one aspect of the field, limiting the therapeutic options. Furthermore, Yontef cautions against thinking that does not include the whole person as agent, citing the notion of the 'top dog' and 'underdog' as an example. In dissociative processes the self becomes fragmented into sometimes structurally distinct parts, of which usually only one is available or figural at any moment. However, by emphasizing experiential moments – the focus on figure or parts – we lose sight of the person who is experiencing (Yontef 1993: 266). There is much therapeutic potential in substituting the word 'and' for 'but'.

The Polsters (1973) and Zinker (1977) are in agreement that polarities represent the inner struggles of the client, Zinker describing them as 'a conglomerate of polar forces, all of which intersect, but not necessarily at the center' (p. 196). In a traumatized system the intensity of these conflicts will mitigate against a cohesive and coherent sense of self. Zinker goes on to say that '[t]here are massive holes in the awareness of a disturbed person. He has a rigid, stereotyped view of himself' (1977: 200).

Rigidity, chaos and complexity

The new science of complex adaptive systems has created a paradigm shift in our understanding of natural, biological and ecological processes, and can be applied across numerous fields of study, including human physiology, relationships and psychology. Complex adaptive systems are defined by their dynamic, self-organizing and emergent properties, which can be seen as ways of describing integrated healthy processes. These processes correlate to the notion of organismic self-regulation, because

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they are spontaneous and have 'no internal or external executive center that directs [their] functioning' (Grigsby and Osuch 2007: 40).

Siegel uses an analogy to illustrate self-organizing tendencies: 'If you just assemble choir singers, devoid of a plan or a conductor, they will generally find a way to sing together in a self-emergence that has vitality and a sense of life to it' (2012: 28-15). We have a natural tendency to move towards maximal complexity (Siegel 2010: 141) which is made possible by linking differentiated elements to one another (p. 134) and creates stability (Siegel 1999: 219). There is such a high level of convergence between the properties of complex adaptive systems and the principles underlying Gestalt therapy that it merits further consideration. For the purposes of this discussion, however, we confine our thinking to the application of complexity theory to trauma.

When a system does not move towards complexity it can be seen as stressed. A stressed system or organism, of which trauma is an extreme and particular example, does not organize towards complexity. Table 3.1 illustrates the inherent complexity of Gestalt principles and its unique suitability to trauma work. The more stressed a system becomes, the more likely it is that it will diverge from complexity by polarizing. Two polarities that result from stress, and which can define mental ill health (Siegel 2012: 16-3) are chaos (cacophony) and rigidity (monotony) (see also Siegel 1999: 220; 2007: 198). Such deviations move the system to either side of complexity. Either of these states limits the movement of the system as a whole towards emerging complexity and adaptation to the environment

Table 3.1 Complex and stressed systems

Complex Adaptive Systems	Traumatized (Stressed) Systems
• Continuous	• Interrupted
• Flexible	• Chaotic, rigid
• Holistic	• Reductive
• Non-linear	• Linear
• Probabilistic	• Seeks predictability
• Spontaneous	• Habitual
• Differentiated	• Undifferentiated
• Integration between parts	• Discrete entities
• Specificity	• Generalization
• Inter-relatedness	• Self-preservation
• Resilient	• Unstable
• Intangible	• Reified
• Energy modulated	• Energy conserved or aggravated

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(Siegel 1999: 220). Gestalt therapists will be familiar with a parallel concept of being *underbounded* or *overbounded* (Kepner [1987] 1999; McConville 1995).

Many trauma symptoms can be understood as representations of chaos or rigidity. This is the hallmark of unresolved traumatic states. Finding areas of chaos or rigidity in a person's life enables us to identify which structures of the ground need to be the focus of intervention. This thinking evolves from that of Perls et al., who saw chaos as undifferentiated ground ([1951] 1998: 58). It is important to understand that in any one individual's system, both chaos and rigidity will co-exist as polarized entities, and may occur as concurrent processes, neither of which is clearly differentiated. It would be a mistake to believe that stressed systems are not self-organizing and adaptive to experiences. We cannot *not* organize and adapt, but under certain conditions do so in the direction of fragmentation and self-preservation, rather than in the direction of complexity and integration.

Complexity theory offers a further idea, known as the 'edge of chaos', which describes a system which is neither too orderly, stable and predictable, nor too fluid, chaotic and unpredictable (Piers 2007: 167). This condition of being on the edge of chaos relates closely to the Gestalt therapy notion of the safe emergency, the point at which intervention is most likely to be effective. Being on the edge suggests a fine line, and it is true that complexity theory posits a tipping point or threshold which represents a transition between states. This can be compared to Siegel's proposition of a range of experience between states of rigidity and chaos, in which maximal complexity, fluidity, stability, resilience and integration are achievable. The fine line attains breadth in this perspective.

Complex systems are understood as having a 'tipping point', or threshold, at which a small intervention has a big effect. It is this tipping point that we seek to find with our trauma clients, though it is never possible to predict what, how or when this tipping point will present. In keeping with this, Erv Polster considers that fluidity is the very force which leverages change (2012: 17). These ideas will be explored further in the next two chapters.

Restructuring the ground

In Chapter 2 the argument that change can only happen within an enlarged field of choice was presented, and the severe limitations on choice for trauma clients has been a theme of this chapter. It is clear that in order to support more vivid integrated self-processes we need to attend to the structure of the ground. Nevis comments that 'It is possible that we can

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create new ways of enhancing figure possibilities through work to enhance the ground by addressing more fully levels of system greater than the intrapsychic world' (2001: 180).

This is particularly apposite in trauma therapy, for which to do anything other would, to use Kepner's words, be 'like trying to repair a house whose foundation is faulty by reconstructing its second floor walls' (2002). He says elsewhere that '[w]e cannot expect the survivor to change ways of being that have worked so well for her in desperate conditions unless we have first helped her to develop new resources in the present' (1995: 64). The availability of choice, or lack of it, may have contributed significantly to the development of trauma symptoms in the first place, and it is therefore potentially retraumatizing to face the 'task of remembering without any more choices than he had when the original abuse occurred' (Kepner 2002: 64). The field changes when more possibilities are allowed into it (O'Neill 2012: 145). Specifically applied to polarities of rigidity and chaos, Philippson observes that: 'If the world is too ordered, there is no place for us to choose. If it becomes too disordered, choosing becomes mere randomness' (2009: 14).

Organismically we solve problems not by getting rid of them but by incorporating new material (Perls et al. [1951] 1998: 249). We do this most effectively by taking the glare off the trauma. This can be achieved in a number of practical ways. Delisle stresses the importance of not getting drawn into the story (1999: 128). Cohen is among others who advise that clients learn to set aside their troubling thoughts, memories and feelings: 'Therapy should focus first on enabling the client to turn away from the traumatic figure' (2003: 44), and pay attention to some alternative aspect of the field. Straight away, the trauma figure enlarges to one of 'trauma *and* . . .'.

Attending to another part of the field begins to reorganize experience, by creating some distance between the trauma and the rest of the experiential field. Thus trauma is held in a reconfigured context, providing containment. This simple intervention presents clients with an immediate choice, one of which they are unlikely to have been aware. The client thus becomes more of an agent in their own process; planting the seeds of realization that focus on the trauma is something they can take responsibility for. Of course this intervention will need to be repeated over multiple iterations in order for it to be assimilated as a viable choice. This is not offered as a rote procedure, but as a response to the intensity of the trauma figure in the moment.

Endless possible alternative figures can be suggested. Attention can be directed to embodied processes such as breath or posture; to orienting to present surroundings; to reminding the client about an experience of calm or safety – all are possible and relevant at different times. It can be helpful to offer the sound of a bell or the smell of an essential oil on a

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tissue. So long as the direction of the attention is towards something positive and healthy the polarity of the trauma is established. A neurobiological perspective would be to consider this as promoting the development of new neural pathways over time.

Alongside this capacity to turn away from the trauma, there needs to be a focus on building a range of positive resources that the client can come to rely on as part of the ground structure. The significance of resources is recognized in a number of contemporary approaches to working with trauma, including EMDR and Sensorimotor Psychotherapy. A resource can be defined simply, to use the phrase Lynne Jacobs (2006) attributes to Malcolm Parlett, as 'that which enables' the client to become more stable and strengthen resilience.

Resources need to focus on the capacity to regulate emotions, regain a sense of control, define boundaries, develop new perspectives and reflect on experience. There is an overlap between the idea of resources and Kepner's emphasis on self-functions, which he describes as 'the means by which the self organizes, manages and modulates the process of contact' (1995: 59). With the support of the therapist, the client needs to be able to recognize and acknowledge existing resources, including current competence in adult life and 'survival' resources that enabled them to cope with past traumatic challenges (Ogden et al. 2006: 207). Further new resources can be added in the spirit of creative experimentation as needed. It seems that a wide variety of resources is necessary, both to relieve the boredom of endless repetition, and to enhance access to them via different channels. It is not so much the content of the resources that matters as the state that it evokes.

Almost anything can become a resource so long as it leads the client into a positive state. The possibilities cover multiple realms of human existence, from the creative to the spiritual; from the relational to the skilful; from the imagined to the embodied; from the past to the future. Resources include creative adjustments in the past and disowned or unavailable polarities. By altering the structure of the ground and enlarging the field of choice, resources can be seen as new creative adjustments, and represent the beginnings of flow within a previously stagnant system, the emergence of vitality.

There can never be too many resources and they may continue to be developed throughout the duration of therapy, even after the therapeutic relationship has become a resource in its own right. Having said this, it is possible to over-compensate by leaning too far into the missing polarity; this indicates the need for pacing and grading in developing resources in order for them to be fully assimilated. Finding just the right amount of tension, for example, helps a client really differentiate their experience. The continual return to and repetition of resources strengthens and adds depth to the ground; a strong ground cannot be one-dimensional.

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Resources and the body

Valuable resources may focus on cognitive, creative or spiritual dimensions, which need to be assimilated as a felt sense. In addition, the body can be seen as a resource in its own right. Many clients who have experienced trauma have a complex relationship to their body. It is a common experience to sense that the body has let them down in some way, by not being able to defend, by being vulnerable, by means of physical injury or arousal during sexual trauma. Later on, the body becomes the container of overwhelming distress, memory and intrusive reminders of the event. It is characteristic to manage such experiences by shutting down on sensation and the potential for aliveness and grounding based in the body. The body self comes to be seen as wholly negative, sometimes as an enemy to be attacked by misuse of substances, self-harm or distressed eating.

Kepner sees resources as a way of resensitizing the body (1995: 101), however it is not adequate to use them as routes to feeling pain or distress; they have to involve pleasure and ease to be accessible to trauma clients. Furthermore, we need to approach resourcing via more than one mode/sense because integration does not result from one brain system alone (Grigsby and Osuch 2007: 49). The idea of somatic resources is common to body therapists, and more recently has come to attention via Sensorimotor Psychotherapy for trauma, and elsewhere.

Being positive about the role of the body is implied in the survival resources mentioned above. 'How did your body help you to survive?' is an enquiry that can reap rich results for trauma victims. Initially they may resist exploring this because it is difficult and contrary to their immediate felt experience. However, it is worth persisting with this line of exploration over time, because even a small recognition of the resourcefulness of the body can have a significant impact (see Chapter 13 for an example). Exploring physical prowess or successes as a child can be immensely helpful for clients traumatized as children. The loss of grounding function of the body leads to disastrous disconnection from the truth of one's own personal story (Goodwin and Attias 1999a: 5). Experiments to exaggerate a physical process, such as increasing tension, can help clients to find the more resourced polarity.

Immersion in the positive

Establishing a felt sense of being in a more resourced state cannot be stressed enough. Most trauma clients will admit that nothing changes for them unless they can feel into the new resource, knowing it through the body and not just as thoughts or ideas. Unless we work 'bottom up' we will

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not influence the structure of the ground. Equal attention needs to be paid to the subsiding of the figure as to the emergence of it – that is, the phases of satisfaction, assimilation and withdrawal.

In a somewhat different context, but which is pertinent here, Bromberg speaks of the extraordinary degree of growth that is possible by means of a 'controlled but consuming immersion by the patient in something positive' (2001: 89). This is an instance in which trauma therapy needs to be pleasurable: 'It is a truism that the self-resourcing skills to recover from trauma are best learned when in a non-traumatised state, and one of the difficulties that arises in any trauma treatment is to re-focus the patient in a positive way in the direction of what is healthy' (Cook 2012: 58). An interesting corollary of complexity theory is that relatively small inputs can lead to large and unpredictable outcomes (Siegel 2010: 252), which is borne out in clinical practice.

Clinical vignette

Rich came into therapy after losing his job. He had been bullied by an executive in a corporate business, and was pursuing a claim for constructive dismissal. He felt both betrayed and a deep sense of failure, and was very irritable with his partner and children, which jeopardized these relationships. The more Rich felt he was falling apart, the more he was withdrawing into a solitary state. When we followed his phenomenology of being around other people, Rich saw the association between sensations behind his eyes and his reactions to his former boss, and also with an experience of having been mugged in broad daylight on a busy high street some years beforehand. We explored together what had helped him get through this initial trauma, and he began by recognizing that he had been raised to believe that 'big boys don't cry'.

This did not produce an immediate positive experience for him, but when he stood back from this he could claim for himself that he had developed a certain bloody-mindedness. His energy rose quickly around this new figure, his eyes and skin tone brightening, his shoulders and head more upright. This was the resource that we lingered with, establishing a sense of how various dimensions of his embodied self accompanied it and we paid attention to the positive value and meaning of Rich's bloody-mindedness. In subsequent sessions, Rich reported a great improvement in his relationships at home, reconnection with social contacts, a rekindling of joy in his life and a new understanding that his life did not depend on the outcome of his employment tribunal.

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Summary

Gestalt therapy pays close attention to how we organize experience. One way of thinking about the organization of experience is to consider what is 'figural' in the foreground and demanding attention, and what is in the background. In respect of traumatized individuals we seek to understand how they include trauma in their organization of the field. It is characteristic of these clients to pay very focused attention to those aspects of their field that are associated in some way with their traumatic experiences – these are their 'figures' that arise from a ground that contains the same experiences. For these clients, therefore, figures do not arise and recede with the spontaneity and vitality we would expect to see in a healthy process.

A further way we organize our experience is by means of creative adjustments, which are contextually responsive. Significant compromises have to be made to adjust to and accommodate trauma. Because traumatic events are so overwhelming, they cannot be organized into meaningful wholes, parts of them being split off or polarized. The study of complex adaptive systems is helpful in providing a way of reconceptualizing the ways organisms self-organize in relation to stress, by diverging from complexity towards ridigity and chaos. It also offers the potential to intervene by finding a more fluid state between these polarities.

In order to work effectively with trauma it is necessary to pay more attention to the structure of the ground than to the compelling figures of distress contained in the story. By enlarging the experiential field to include additional aspects that may have previously been disavowed or unavailable, the figure of trauma is held in a more spacious way which reduces the intensity of the figures. Clients can be encouraged to develop a wide range of resources which represent disowned polarities and alternative healthy creative adjustments. Particular attention needs to be paid to embodied resources, harnessing the capacity of the body to integrate and organize experience. With an expanded field of choice, the client begins to reorganize their sense of self, to include the experience of self-as-agent.

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4 Working with arousal

This chapter follows from the last in some of its thinking about complexity and resourced states. We explore how figure disturbances of trauma go hand in hand with a physiological disturbance of arousal. This in turn activates instinctive organismic defences related to threat or the perception of threat. We go on to explain the mechanisms of arousal, making links to the Gestalt theory of arousal and figure formation. This provides some theoretical ground for understanding the ways of taking the glare off the trauma. The Window of Tolerance Model, which is a key to working with trauma and therefore central to this volume, is presented and explored at length and provides a coherent rationale for the clinical application of arousal theory. This model overlaps with the theories of complex systems and polarities addressed in the last chapter, making a more nuanced approach. Attention is paid to ways of working with states of dysregulated arousal.

Trauma as a problem with arousal

In his seminal paper 'The Body Keeps the Score' (1994), van der Kolk noted that the psychological effects of trauma are expressed as changes in the biological stress response. He describes a bi-phasic reaction: hyper-reactivity to stimuli and traumatic re-experiencing which co-exists with psychic numbing, avoidance and amnesia. According to him, there is a typical pattern of numbing to the environment punctuated by intermittent hyperarousal. Kepner describes this in the language of polarities: stimulus is like a binary function, either off/on, overwhelmed/numb (1995: 75). Loss of the ability to modulate emotional experience is central to PTSD. Van der Kolk's paper also looked at the stress chemicals involved in PTSD and the part they play in the maintenance of arousal: 'Chronic exposure to stress . . . permanently alters how an organism deals with its environment on a day-to-day basis, and it interferes with how it copes with subsequent acute stress' ([1996] 2007: 223).

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Boadella speaks of the capacity for emotion to either mobilize or paralyse the body (1987: 4), and which way an individual responds will depend on their experiences and creative adjustments. Many of the creative adjustments a client makes serve to regulate arousal. For example, 'aboutism' or intellectualizing often fulfil this function. Sapriel (2012: 107) observes that in the face of trauma children learn that emotions, arousal and action are dangerous, and the same is true for adults unable to tolerate the onslaught of trauma-related feelings.

Self-harm, angry outbursts and destructive behaviours can also be understood as moderators of arousal, as can self-medicating behaviours involving abuse of alcohol and prescribed and non-prescribed drugs. Another example is of a client who regularly had some sort of crisis a couple of days after a regulating therapy session and was unable to tolerate or sustain positive states. It is common early in therapy for trauma clients to have strong primitive affects but be unable to integrate them (Yontef 1993: 262), which underlines the importance of Kepner's phased Healing Tasks Model of trauma therapy. Learning to manage stimulus is a self-function and a property of a self-organizing complex system. Gestalt therapists will recognize the relevance of the glue and solvent metaphor of Stratford and Braillier (1979).

Arousal and Gestalt

Arousal has been of interest to thinkers and writers in Gestalt theory since its inception, long before van der Kolk's published work on the physiology of arousal in trauma. So central are ideas associated with arousal that the 'bible' of Gestalt theory written by Perls, Hefferline and Goodman in 1951 uses the word 'excitement' in its subtitle. Arousal is implicit in two fundamental Gestalt concepts: organismic self-regulation and the cycle of experience – the process of figure formation. Contact, implicit in figure formation, is a valued and sometimes idealized notion in Gestalt. Spagnuolo-Lobb comments that 'the term "contact" implies consideration of physiology in the experience' (2009: 112).

Energy is required to support the development of a figure, and contact can be viewed as the turning point from which that energy subsides. The quality of contact is therefore contingent on the available energy that can be brought to it. Gestalt therapists attend to the processes involved in contact and the ways in which it may be modified. While there is a current debate about the validity and usefulness of individual moderations to contact which is beyond the scope of this discussion, it is, however, helpful to consider that we regulate the arousal of contact according to our ability to tolerate it.

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Other Gestalt writers link contact with regulation of the metabolism. Levin and Levine state that organismic self-regulation occurs at the point of contact between the organism and the environment (2012: 3). Philip Brownell in particular has explored the links between self-regulation, contact and neurobiology (2009), coming to the position that Gestalt therapy is not merely concerned with holism but 'a literal understanding that physical functioning affects mental status' (p. 64). He says this: 'Physiology of the organism (its basic metabolism and sensori-motor functions) supports the psychology of contact at the boundary of the organism-environment field and is essential to its dynamic' (p. 65). Furthermore, he posits that 'What Gestalt therapists call self-regulation can be largely explained by the neurological construct of executive functions … [the] "executive center" of the brain is where the organization of a person's sense of self comes together' (p. 67), although this is not mainstream Gestalt thinking.

These executive functions are associated with higher-order brain functions of the cortex. Recall that in Chapter 2 the compromised availability of the higher-order functioning of the cortex under extreme duress was described. The implication of this is that when integrated brain function is disturbed by trauma, the client is unable to self-regulate. Thus, the organization of the layers of the brain are related to the capacity for self-organization or regulation. Executive functions are a subset of self-functions, including the ability to think before one acts, to manage emotions and to initiate purposeful action, all being particularly problematic for trauma victims. Brownell concludes: 'It must be recognized that self-regulation and executive functions are overlapping, if not synonymous' (p. 78).

Perls et al. understood that there are situations in which self-regulation is fallible, giving the example of a child in danger of running in front of a car ([1951] 1998: 275). This leads to the conclusion that *there is a threshold beyond which the organism is unable to self-regulate* according to prevailing field conditions, and requires help to do so. Trauma theory confirms this.

Further consideration of the issue of emotional regulation in relation to figure formation is provided by Delisle, who recognizes that '[t]he therapist has at his disposal a whole array of techniques designed to activate and heighten experience. All the same unconsidered use of these techniques can put him in the position of the sorcerer's apprentice, capable of unblocking things without really knowing what to do with what has been unblocked' (2011: 75). This is a key point, identifying the problem that exists for a number of Gestalt writers who understand the importance of physiological effects, but not necessarily what they are and how they work, and who don't supply a solution. The Window of Tolerance

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Model, to be described below, is one way of resolving these difficulties. But first we need to understand the physiological mechanisms that explain what's going on. After all, as Bowman says: 'The domain of Gestalt psychology was clearly the scientific study of the nervous system' (2012: 31).

The autonomic nervous system

We cannot work with the disturbed arousal of trauma clients without understanding the role of the autonomic nervous system (ANS). Stauffer describes it as a 'part of the nervous system that deals with all the life processes that we cannot control with our conscious volition' (2010: 49). Physically separate in structure from the central nervous system which is organized in a specific segmental arrangement of the spinal cord, the autonomic nervous system 'appears to be designed to broadly disperse any stimulation throughout its web-like network, *creating a general response*' (Juhan 2003: 292, my italics). Thus the effects of the ANS are felt through many organs of the body. The ANS is responsible for modulating arousal; in Stauffer's words, its role is to 'get our juices flowing' (2010: 51). This is because the ANS operates on smooth muscle, literally helping to move fluids around (Stauffer 2010: 51). Activation of the ANS is accompanied by a surge of neurochemicals throughout the body.

There are two branches of the ANS which are respectively called the sympathetic and the parasympathetic nervous systems. The sympathetic branch of the nervous system mediates the flight-or-flight response associated with threat and anxiety; it also has qualities of spontaneity and vitality. One client described this as feeling as though 'all my senses are cranked up'. The parasympathetic branch is involved in states of relaxation, recovery and assimilation. Further, the parasympathetic branch arises from deep cranial nerves, including the vagus nerve (see also Chapter 10), to the extent that the two terms are sometimes used synonymously (Stauffer 2010: 51). The vagus nerve controls blood pressure and therefore heart rate, operating what is known as the 'vagal brake' to increase activation, having an immediate effect on states of activation and relaxation, with consequent alterations in breathing. 'The parasympathetic vagus nerve that can speed up (vagal inhibition) or slow down (vagal activation) heart rate interacts in the brain stem with the respiratory motor neurons of the phrenic and skeletal muscle nerves' (Fogel 2009: 232). Related to the function of the vagus nerve is the Poly Vagal System, identified by Stephen Porges, and discussed in Chapter 10.

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Clinical implications of the ANS

The clinical implications of the ANS in relation to trauma are significant and merit being placed at the centre of our thinking. Stauffer explains that trauma can be defined as a state of autonomic overwhelm that becomes unable to resolve naturally (2010: 56). The function of the ANS moves the individual into physiological states associated with fight, flight and freeze, each related to survival instincts when danger is detected. A critical point in this respect is made by Fisher: 'The very same responses that preserve our physical and psychological integrity under threat also drive the symptoms of post-traumatic stress for months or years after the events themselves' (2003).

The two branches of the ANS do not necessarily operate in a simple see-saw balancing action as we might imagine. Research suggests instead that there is a matrix 'consisting of a multiplicity of possible states of activation of the two branches' (Stauffer 2010: 51). This can result in states of high activation of *both* branches simultaneously, leading to the freeze response sometimes called 'tonic immobility' (Stauffer 2010: 51–2; see also Chapter 7). This explains why trauma victims are often continually in a condition of dysregulated arousal, either because of chronic activation of the sympathetic branch or because of *concurrent high activation of both.* In such a state the person is unable to process anything, even the therapy session, and it is necessary to intervene to allow the parasympathetic branch to assist in calming the person (Stauffer 2010: 56).

The ANS has many sensory nerves, and it is this that helps with the process of interoception – the feeling of internal states (Kepner 2002) – which needs to be taken into account in resensitizing the body. Breathing is a particular way in which we can understand the role of the ANS, inhalation being in the domain of the sympathetic branch, and exhalation being in the realm of the parasympathetic; it is a self-regulatory function (interview with Speads, in Johnson 1995: 41). Most therapists will observe how their clients' breathing changes when they are upset or panicky, for example. It may be that by holding the breath the client is able to limit the amount of stimuli to attend to, which modulates arousal, but it also holds a charge in the body and some clients will need help to attend to their outbreath.

It is not surprising that many relaxation techniques involve attention to the breath in one way or another; the breath, like blinking, is under both voluntary and involuntary control. Observation of breathing is therefore a source of good information about arousal states. It is interesting to consider that by regulating the breath, changes in blood pressure may be communicated from the body to the deep emotional brain via the vagus nerve, an internal feedback loop. This kind of process is attracting

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considerable attention in the form of study into heart-rate variability, the difference in time between heart beats, which indicates the balance between the two branches of the ANS (Gilbert 2010: 297). Gilbert considers that people can be trained to improve their heart-rate variability in various ways (p. 297).

Experiment

Take your right hand and place it about an inch away from your chest over your heart – close but not touching. Imagine compassion flowing into you and into this area through your hand. Notice if you feel any heat there. Maintain a soothing breathing rhythm as you do this exercise. Sometimes people like to associate a colour with compassion, so you can also imagine a colour of compassion flowing into your heart area, without condemnation.

Now, from this compassionate position, bring to mind the part of you that has had anxious, angry or upsetting experiences, and imagine this part in front of you. Look at your facial expressions and behaviour. Imagine what that part is feeling and thinking. Now simply send compassion to that part of yourself. Try to really feel compassion for it. Don't try to change anything – just sit looking at that part and feel compassion. You recognize that these emotions are from the threat system and are related to fears and upsets.

As you stay with this experience, notice if anything changes in your muscle tone and your emotional state, and whether you have different thoughts or overall sense of experience.

(Adapted from Gilbert 2010: 298–9)

The Window of Tolerance Model

Chronic arousal of the ANS means that trauma victims have difficulty tolerating stimuli and tend to shut down by desensitizing from their bodies or by moderating contact as an attempt to self-regulate. However, trauma theory demonstrates that ANS activation takes the victim beyond the threshold at which their metabolism can automatically regain a regulated state. It is the activation of the ANS that produces a chronically and deeply embodied polarized condition. Kepner confirms the need for trauma clients to learn to manage intensity as well as feelings in the middle range (1995: 85). 'Affect tolerance, which allows for the experience of emotion to enter into consciousness, is related to the capacity to bear pain'

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(Schore 2003a: 24). Clearly, in order for any trauma therapy to be effective we need to establish a condition in which the client learns to tolerate and process experiences, including increasingly strong primitive emotions of fear, anger, grief, love and joy and is able to function well. To do so means nothing short of transforming the experience of trauma into the vitality and fullness of human existence.

Fortunately, there is somewhere on the continuum that we can conceptualize between the polarities of arousal that represents optimal arousal. Siegel proposes that we all have a '"window of tolerance" in which various intensities of emotional arousal can be processed *without disrupting the functioning of the system*' (1999: 253, my italics). Sensorimotor trauma therapy has adopted this model as a key to recovery (Ogden et al. 2006: 26ff). The window of tolerance does not have fixed parameters; constitutional factors determine these and so can experiential learning (Siegel 1999: 255). Furthermore, the window of tolerance can vary for any individual in response to current conditions – it is state dependent. When we are tired or hungry we become rather less tolerant, and our field of attention is reduced; external factors such as being in a traffic jam or hearing a sudden loud noise affect us similarly (see Figure 4.1).

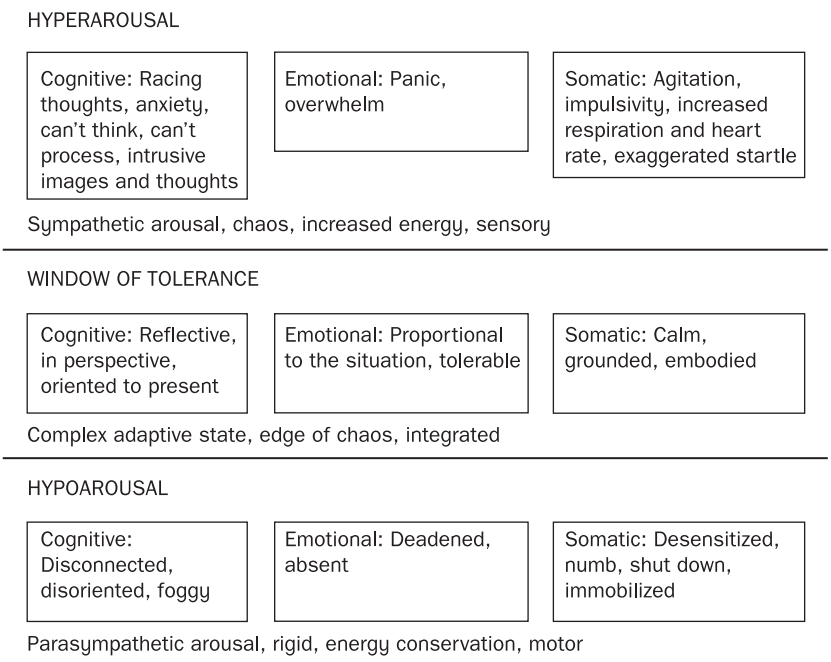
HYPERAROUSAL
Cognitive: Racing thoughts, anxiety, can't think, can't process, intrusive images and thoughts
Emotional: Panic, overwhelm
Somatic: Agitation, impulsivity, increased respiration and heart rate, exaggerated startle
Sympathetic arousal, chaos, increased energy, sensory
WINDOW OF TOLERANCE
Cognitive: Reflective, in perspective, oriented to present
Emotional: Proportional to the situation, tolerable
Somatic: Calm, grounded, embodied
Complex adaptive state, edge of chaos, integrated
HYPOAROUSAL
Cognitive: Disconnected, disoriented, foggy
Emotional: Deadened, absent
Somatic: Desensitized, numb, shut down, immobilized
Parasympathetic arousal, rigid, energy conservation, motor

Figure 4.1 The Window of Tolerance Model

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Not surprisingly, many trauma clients have a restricted window of tolerance. As one said to me after a stressful journey to her session, 'My tolerance levels are paper thin'; this model speaks to the heart of the client's phenomenological experience of safety and danger. Because of this, it is invariably supportive to clients to share a version of this model with them, and to help them identify those states that are most familiar to them; doing so normalizes and provides a context for their experience, in addition to offering them the possibility of something different.

It is important to understand that this is not a linear, either/or model, but represents the possible matrix of arousal suggested above. It is wise to be cautious about thinking that this model is merely reductionistic, because it is really a map of the extremes of human suffering. In Part 3 of this volume the Window of Tolerance Model is developed as an interactive systems model rather than a representation of unitary functioning. It is a theoretical and functional model which overlaps with complex adaptive systems theory of chaos, rigidity and the edge of chaos.

In Chapter 3 the case for the 'edge of chaos' to be quite broad was presented: a wide window of tolerance. In working with this model the first task is usually to establish a point of stability and calm, which sits theoretically at the mid-point between hyper- and hypoarousal. This state is one in which not very much can happen therapeutically, and is sometimes experienced as boredom by clients whose chronic overload of adrenaline is more familiar. For those clients who find *any* stimulation to be unbearable, it is necessary also to find neutral and apparently meaningless experiences. Nevertheless, this state is an essential one which allows for the integration and assimilation of experience. It is a state of just being present and open to sensation and emergent experience. It is a state, paradoxically, of simplicity, because of its clarity of figure formation, coherence and quietude.

Trauma therapists need to work extensively and thoroughly at the margins of the window of tolerance, learning collaboratively with the client what takes them beyond their capacity to tolerate, and the subjective phenomenology of this process. It is important to be able to distinguish clearly the signs of both incipient hyper- and hypoarousal, in a continual and ongoing process of assessment, moment by moment. This allows for finely balanced calibration of arousal: neither too much, nor too little but just enough. The client's ability to stay in the window of tolerance or not informs the pacing and grading of the therapy on micro and macro levels, and is therefore an invaluable diagnostic tool.

Hovering near the thresholds of tolerance, finding the tipping point and the way back to the resources within the window of tolerance over

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and again, is by far the most time-consuming part of trauma therapy. It is also potentially the most rewarding for both the client and the therapist, because of the symptomatic relief it brings. Shub recommends 'Systematic, repetitive, therapeutic experiences to loosen what is deeply lodged' (2000: 81). Incrementally, the client learns to be present to their aliveness, including their own suffering. Of course we can never tell when or by what means the client will find that tipping point which enables their recovery, either in the moment or over the course of therapy; we can only persist and be patient, trusting in the process and the body's innate ability to regulate. However, it is true that the body usually takes longer to enter a completely regulated state than the cognitive or emotional recognition that the conditions are favourable would suggest. This is good reason for lingering for extended periods of time within the window of tolerance.

Because so much time in trauma therapy is spent working with the window of tolerance it can come to look as though it is the whole of the therapy. This is not the case at all; it is an entry point and a means to an end. Learning to regulate arousal is a key self-function without which the others cannot develop. As the client becomes more able to access resources within the window of tolerance over the course of therapy they will begin to be able to sustain figures with increasing charge. It is as though the margins of the window expand. Powerful emotions such as rage and grief are possible within the window of tolerance, the most salient consideration being the client's ability to remain present to these.

Gestalt therapy includes the concept of the 'safe emergency' (Perls et al. [1951] 1998), which can apply to the margins of the Window of Tolerance Model, at the very 'edge of chaos'. Being in the window of tolerance allows for depth and breadth of work consistent with complexity thinking, a space in which the client can come more into contact and in which trauma can ultimately be worked through and resolved. No longer is this a space where little happens, but one in which growth and healing can take place. Crucially, as the backbone of trauma therapy, the window of tolerance implies an increased sense of embodiment and points therapists towards attending to body process.

Working with arousal

There are some principles of working with arousal that apply to both extremes of the modulation scale. Perhaps it is stating the obvious, but it nevertheless needs to be stressed that the rule is this: *never work with a figure until you have gathered enough support*. This can do harm or even re-traumatize the client: 'until feelings can be experienced without

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overwhelming the survivor and reenacting the original trauma that created the need to dissociate or blunt the feelings, strong expression of feelings is damaging rather than healing' (Kepner 1995: 84). Tell your client that you will be checking with them repeatedly to ascertain their level of arousal by asking 'Can I just pause you there for a moment?', and suggest they monitor their changing arousal as well. Kepner advises therapists to 'attend to signs of the client being "full"' (1995: 81). By putting in regular and fairly predictable 'stops', regulation will automatically increase because they permit more parasympathetic activation; Rothschild speaks in this regard of 'putting on the brakes' (2000: 79), and lends support to the figure. This is a way for you both to learn to recognize when to back off a bit, return to a resource before continuing, or drop the subject for the time being.

If your client wants to tell you something trauma related or potentially triggering, negotiate with them first what supports they need to help them stay as present as possible. By asking them to reflect in this way regulation will increase. The process of phenomenological description is a further way of supporting regulation, especially of body process that the client may be able to observe for themself. At either extreme of the scale, once regulation is established it is important to linger with it and to create new organizations of experience, joining and integrating how the rest of the body can be included in this, with the thought processes and felt emotional sense of this resourced state. A client commented: 'When I tried to manage this on my own it always escalated and went out of control. The way you bring me back and stop it going over the top means I can talk about it, it changes me into someone who can deal with what happened.'

Working with hyperarousal

Phenomenological observation of signs that the client is moving out of their window of tolerance in the direction of hyperarousal will reveal some of the following: agitation, shallow or quickened breathing, jumpiness, eyes darting or scanning, higher pitched voice, increased speed of speech and multiple figures being presented. You may also notice changes in skin tone or colour and dilation of the pupils. Some emotions are associated with sympathetic arousal, including anger, rage, fear and joy (Schiable 2009: 35). Learning to spot changes in the client's energy is helpful too; energy can have the quality of being higher or of flaring or blazing, and you may simply notice a sense of heat. The increase in muscle tone that often accompanies this constellation of signs is different from that associated with hypoarousal. Try the following experiment to help you get a felt sense of this.

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Experiment

Tighten your muscles as though you were frightened, anxious or panicky. This is tension associated with preparation to move – to hit or kick or run. Notice what this feels like. Now tighten your muscles like the proverbial rabbit in the car headlights. This is tension associated with staying extremely still; freezing. Compare the difference.

Once you can distinguish between the two for yourself, you are more likely to be able to spot what is happening in a client's body. In addition to these observations of your client, you will be likely to pick up similar experiences in your own body and perceptions.

As a rule of thumb, it is most helpful to find the means to slow down the client who is becoming hyperaroused. It is common to come across tropical fish tanks in hospital or dentists' waiting rooms for their soothing effects. Delisle observes that 'One of the best ways to maintain the client's affect is to use interventions that slow them down or that stop at times of emotion, and to do this the instant that emotion becomes present, even very slightly' (2011: 81). This provides not only the needed regulation but a sense of being able to contain and manage the emotion differently. Hyperaroused clients are overloaded by excessive stimulation and need to limit the amount that they are processing in the moment. Most writers agree that attention to sensations is the most effective way of reducing stimulus and thereby calming. You can suggest that clients attend simply to the physical features of their experience at this moment, directing them to drop any associations or meanings that they attach to them. The pace and tone of the therapist's voice are also important in helping to slow things down.

Use of deliberate rhythmic movement can help regulate and give the client some sense of control over their bodily reactions. Some clients like to stand and rock gently from foot to foot, or to sit and rock their upper body from their pelvis. Swinging the arms around the body is another variation of this. In either case finding the slowest possible movement or a gradual transition from fast-to-slow-to-still is often beneficial, and similar experiments can be created using a physio-ball, which is grounding. Mostly, an experimental attitude in which you find out together what is helpful and what isn't is the best approach.

Another way of helping to contain is to find a way of framing a single figure, among others that may be competing for attention: 'Which of these things do we most need to focus on now? Can you put everything else to one side for the moment and just stay with that?' Sometimes it is helpful to

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ask the client just for the 'headline' of their experience and to take note of accompanying changes in arousal. Similarly, asking the client to tell you something in the fewest possible words, like a telegram, can help to frame a figure.

You may want to remind the client about a resource or creative adjustment, or choose to work with the polarity of the current figure. It usually helps to tell the client to take their time over a regulating process, especially close to the end of a session. The use of images can help to increase body awareness, both those elicited from the client and those suggested by the therapist, such as 'Can you think of a calm colour/scene/piece of music and notice the effect on your body?' Romanyshyn comments that 'the imaginal world is by its essence the intermediate world between the intellectual and the sensible' and is therefore a route to sensation (2007: 81). The sense of smell is functionally related to the ANS and you might use aromatherapy oils to help, asking the client to choose the ones that they prefer. Clients can also be encouraged to develop and practise a variety of self-soothing strategies outside of sessions, especially for 'emergency' situations (Fisher n.d.).

Clinical vignette

Susannah became distressed by a painful body memory in her pelvis during a session. Her breathing was shallow and staccato, her inbreath shorter than her outbreath. She said she felt panicky and she tightened the front of her torso. I invited her to slowly explore the experience of the pain, asking a slowly paced series of questions about it. I enquired about the qualities of it, the colour, the dimensions, the temperature, the volume of it. I also asked her to think about any energy in it, any sense of movement and direction. Susannah reported that it was a jagged, dark pain, cold, and solid at the bottom, that went through her right side and disappeared near her spine. I became curious about her sense of the pain disappearing in that way and Susannah was able to get a sense of it dissolving away through a point.

I suggested Susannah explore the edges of the pain: were they clear and sharp or diffuse, how did they relate to the surrounding tissue? I wanted her to get a sense of how the pain was held in her body, how the rest of her body cooperated with this pain. She then reported that the edges of the pain were clear, but softening as she studied them, and that outside the tissue was red and pulsing and tight and angry. 'Oh, that's me, that's where I can feel who I am', she said with surprise, and then 'the pain's going now'. During this process of

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several minutes Susannah's breathing had steadied and she was quiet and focused. Notice that I did not ask her to consider the intensity of the pain because that could have increased her arousal again.

Working with hypoarousal

Parasympathetic states are generally more difficult to work with than sympathetic ones, because they involve the client shutting down, to a greater or lesser extent. So little happens in this state that the work can hold negligible interest for the therapist. There is a very thin line between hypoarousal and dissociation. The 'drop' from hyperarousal to hypoarousal can be quite sudden and dramatic, the client reaching a point at which they can no longer sustain the charge of the arousal.

Signs of hypoarousal therefore include a stilling of the body and breathing, and dilation of the pupils or aversion of the eyes. Muscle tone is usually tightly held, sometimes over extended periods that would in other circumstances be painful, but it may also be collapsed. There is an analgesic effect in hypoaroused or dissociated states which makes this possible (see also Chapters 7 and 8). The client's reactions become slower, and speech is flatter and deeper in tone and may be less frequent as they withdraw from contact. For this client, available energy is minimal and everything appears to be much more of an effort. The amount of effort a hypoaroused client needs to summon in order to become more present is considerable and must not be underestimated. In this state, the quality of the energy present is thick rather than heated. Emotions of sadness, depression and despair are consequent to the parasympathetic dominance of hypoaroused states (Schiable 2009: 35).

Working with hypoarousal is not the converse of working with hyperarousal. There is risk involved in trying to escalate things too quickly because the client might dissociate further or become hyperaroused. In this instance the work needs to gradually restore the available energy and contact. First, try suggesting the client orient themself to the present surroundings (see Chapter 6), by asking them to look at particular objects. It is a good idea to identify something in the room that can remind the client of where they are, a familiar resource that can help them feel grounded (Boon et al. 2011: 19). Naming four red objects or three shiny objects is another common way to begin to bring the client into the present, and sometimes elicits a state shift. It can also help to encourage the client to look at things to either side or in different parts of the room, because this requires some movement of the eyes and head. Techniques from Sensorimotor Psychotherapy are to try pressing the feet into the ground

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or to lengthen the spine a little as though being pulled by a cord from the top of the head. Both of these interventions begin with the periphery of the body but involve the core muscles around the pelvis, spine and abdomen, achieving a sense of stability. Simply standing up together can help enormously.

It can also help to ask the client if they notice any impulse to move, usually in the arms or the legs, or can imagine making a movement that would help. 'Frozen' muscles are part of a movement pattern related to aborted defensive actions in situations where escape is impossible, so there is often a **retroflected** action such as fight or flight that is already known in the body. It may be helpful to think about a muscle tightening in preparation for movement, such as an arm drawing backwards before throwing a ball. It is this process that we hope to capitalize on with hypoaroused clients.

The contraction and flexion of any muscle will begin to increase regulation, particularly when done mindfully. Ideally the client will find a potential movement and be able to tell you, even if it's not possible to do yet. In such a case the therapist can demonstrate that movement, or suggest another in order to mobilize them through engagement of their mirror neuron system (Chapter 11). The fundamental movement patterns concerned with push, pull, reach, yield and grasp (2001) described by Ruella Frank are useful in thinking about how to build movements slowly with the intention of supporting regulation. Most implicit and unintended movements, no matter how small, fall into one of these patterns. Working with the smallest amount of energy that is available or possible is sometimes the best that can be achieved.

Clinical vignette

Quite suddenly my client Lina goes still and looks down. The muscles in her upper arms and chest tighten as do her legs, lifting her feet off the floor. I ask, 'What's happening?'

In a low voice she replies, 'Nothing, I'm alright.'

I tell her, 'I'm sure you know how to be alright by tightening up; did you notice something change just now?' A small pause.

'Don't know,' she says in the same voice, not moving.

'Can you open your eyes and look at the plant over here that helps you know where you are?' I ask her, thinking that contact with me might be too much at the moment. No response. 'It looks like you've gone to that scary shut off place where you remember things,' I say, keeping up the contact. Lina shrugs slightly, she's listening. 'Perhaps we can find a place where you can be quiet and *have some space without taking yourself away. Would you be interested in that?'*

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My thinking here is to suggest a more integrated state without taking away her survival resource of shutting down. 'Maybe, I don't know,' she says. I sense that she's engaging with me, we are in dialogue. 'I wonder what would make this a tiny bit better just now?' Another pause. 'May I make a suggestion? How would it be if I moved a bit closer to you?', I offer, knowing that this has helped in the past. Another pause. 'Whatever,' she says. I take this as permission, and move so that I can place my toes against hers, offering some contact and grounding. I tell Lina that I will stop if she tells me to. She moves one foot away. Her breathing deepens and the muscles in her arms soften. I ask her to let her attention rest on her feet. She opens her eyes and looks into the room. We begin to discuss being in a better place where she can access resources.

Summary

The process of physiological arousal was intuitively understood by the fathers of Gestalt therapy because it is implicit in the energy required to form clear figures, support good contact and self-regulate. Because Gestalt therapists value spontaneity and liveliness, assumptions and expectations were made about the centrality of these processes. However, there was also some early recognition that there are limits to the ability to regulate in some situations. Trauma is an example of this, because a key feature of trauma clients is their inability to maintain a sufficiently regulated state to support contact.

Typically, two phases of dysregulated arousal form part of the trauma response, and these accord with the two branches of ANS arousal. The sympathetic branch is linked to escalating arousal and the parasympathetic branch is associated with decreasing arousal. A reasonably balanced process between the two is sometimes thought to be the ideal; however, there is more often a mesh of different states in trauma clients who may be constantly shifting between either hyperaroused (sympathetic activation) or both hyper- and hypoaroused (sympathetic and parasympathetic activation). The former leads to states of agitation and overwhelm, the latter leads to shutting down and 'freezing'. Each of these states is triggered by trauma-related memories, and therefore in neither space is contact possible.

It has been postulated that there is a window of optimal arousal, called the window of tolerance, conceptualized as sitting between hyper- and hypoarousal. This roughly correlates to the concept of the

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'edge of chaos', in which integration can take place. For many trauma victims, it is access to this zone that is severely compromised. Therefore working to strengthen this zone is central to successful trauma therapy. If we imagine a line across the centre of this zone, the client is able to feel safe, calm and in contact. Both client and therapist need to know that such a state can be attained, and have ways of reaching it. However, it is at the margins of the window of tolerance that much of the work of trauma therapy takes place. In order to provide regulating experiences for the client the therapist and client both need to pay much attention to the transition between this and dysregulated states. This is similar to the Gestalt therapy concept of working with the safe emergency.

Finding ways to halt the therapy process and check on states of arousal is important, providing breaks in which some regulation may take place. In addition, there are particular approaches to both hyper- and hypoarousal which can be effective. Hyperaroused clients in general need help to slow down and settle, because their physiological, emotional and cognitive processes have become overwhelmed. This involves avoiding particular figures associated with trauma and developing those associated with calm. Attention to sensation brings them quickly into their bodies and restores the possibility of contact within the window of tolerance. For hypoaroused clients the slow development of movement, coupled with encouraging orientation to present surroundings, is recommended. This work needs to attend to the impulse to move which may be retroflected, and imagining the possibility of doing something different.

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5 There and then, here and now

Gestalt concepts of unfinished business and the fixed gestalt underpin this chapter. The seemingly unresolvable nature of trauma has a clear time perspective, in which the client continues to live as though the trauma was ongoing. Gestalt therapy naturally orients towards working in the here-and-now which is invaluable in trauma work, helping to consign the traumatic events to the past. We use current awareness and the phenomenological approach to do this. Neuroscience shows us that an integrated state of mind can bring us into a more mindful and embodied sense of the present moment. Trauma clients tend to generalize associations from everyday situations to their trauma, and these linkages are uncoupled by means of using curiosity to differentiate experience in the here-and-now. Reference is made to the Integrated Model of Change, organization of experience and self-regulation, bringing together the themes of the previous three chapters, and provides a methodology for taking the glare off the trauma.

The timelessness of trauma

Although many trauma victims have found ways of functioning more or less successfully in everyday life, for most there is a never-ending background of terror that breaks through unpredictably in the form of flashbacks, nightmares and other intrusive reminders. For many, this fear hovers at the edge of their awareness almost constantly, leading to the state of increased alert to danger known as hypervigilance. Such experiences are quite outside the influence of conscious or voluntary control. It has long been recognized that these phenomena have very visceral qualities, bringing with them intense emotions and escalation of ANS arousal beyond the window of tolerance. There is an immediacy in these reactions that brings the memory of past events tangibly into the present; they are re-experienced not as trauma-related symptoms but as part of current reality.

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To experience an event that leaves you traumatized is dreadful enough; to relive that event over and over again, even over decades, with feelings and sensations at least as vivid as the original event is truly horrific. At the moment of a traumatic event there may be such an element of shock and confusion that there is a degree of numbing to the intensity; when that event is re-experienced the accompanying feelings can be stronger than before. For these victims, the trauma has not stopped; the gestalt is unfinished and the past is all too present. With regard to the trauma, it is as though the interval between the event and the present never existed. Perls noted that '[memories] are not subject to change as long as they remain in a system isolated from the rest of the personality' ([1947] 1992: 104). This is the characteristic of unprocessed trauma: the continual reliving is never truly about memory until it can be assigned to the past.

Clinical vignette

Hilary was 48 when she came into therapy. She had been raped almost three decades earlier by a university lecturer while on a field trip. After some time in therapy, during which we had numerous times focused on current experience, she was becoming more stable and able to function better, but still had times when she was badly affected by her memories of that evening. One day she was flooded by fears that her perpetrator would track her down through social media. I commented: 'You give a lot of power to an old man.' Hilary looked momentarily taken aback. I followed on: 'How old was he at the time he raped you?', to which Hilary replied, 'Oh, I've always thought of him as being the same age as when it happened, but of course he isn't . . . he'd be in his 70s . . . if he's still alive . . . it's so obvious but I never realized it . . . [her energy rising] I'm stronger than an old man . . . I could knock him over, I could kick him, I could really hurt him, show him what he did to me . . .' For Hilary, being able to update her memory by separating past from present completely changed her relationship to what happened and to her sense of self, and this became a turning point in her therapy.

Stolorow evocatively says that 'trauma destroys time' (2007: 17). He goes on to stress the clinical significance of this: 'Torn from the communal fabric of being-in-time, trauma remains insulated from the human dialogue . . . trauma, in altering the structure of temporality, also disrupts one's understanding of one's being; it fractures one's sense of

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unitary selfhood . . . clinical features typically explained as dissociation and multiplicity can additionally be comprehended in terms of contexts of trauma in disorganising and reorganising one's sense of being-in-time' (Stolorow 2007: 20). Dissociation and multiplicity are the consequences of compartmentalization and fragmentation which disrupt the sense of continuity of experience. Fragments of the past re-emerge in seemingly random fashion. 'In trauma-related disorders fragments of memory take on a life of their own, able to intrude at any moment, thereby fuelling hyper- and hypoarousal states that are beyond cognitive control' (Ogden et al. 2006: 155). The need to find some control may be one explanation for why victims become fixated on the past, endeavouring to close the gestalt that seeks completion. Trauma clients' preoccupation with things that have passed is often counterbalanced by a foreshortened sense of the future.

Through the lens of trauma, the present moment takes on a particular meaning. Bromberg observes that: 'For certain people, here-and-now experience – the living present – cannot be . . . mentally represented without the felt danger of traumatization' ([1998] 2001: 214). A client declared: 'I don't *want* to be in the present, it's *too awful!*' This presents both a warning and a conundrum for Gestalt therapists whose orientation is to work in the here-and-now. Fortunately, the Window of Tolerance Model presented in the previous chapter contains a temporal dimension. The window of tolerance is a zone in which it is possible to be in the here-and-now, and anything outside of it is in a different time frame. Trauma clients become locked in time physiologically because of their dysregulated ANS arousal, as represented by states of hyper-and hypoarousal on the model.

Beyond the here-and-now

Because he considers that the here-and-now espoused by Perls is not enough, Yontef refers to four time spaces which we need to take account of in therapy. First, '[w]e center on here-and-now moments of experienced contact, but that is not the end of our horizons' (1993: 260). Second is the 'there and now' frame – the person's life space outside the therapy room. Next is the 'here and then', the therapy context, meaning 'that which happened here in the therapy room, but not at this very moment', for example the development of the therapeutic relationship over time. A client said of therapy: 'This is where the past and present come together', and I agreed that I was a part of that. Finally comes the 'there and then', by which is meant the person's life story (Yontef 1993: 260–1). Thus Yontef embraces a whole-field perspective which opens the possibility of

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honouring the client's past, their current concerns for safety and creative adjustments over time.

More recently, Delisle has expanded these four fields of time to include internal and external levels for each (2011: 21). His thinking can be applied directly to trauma: 'it is not the historic past that is at stake but the past as it acts upon the configuration of the present field' (Delisle 2011: 20). For clients such as Hilary above whose trauma occurred decades ago, we are not simply dealing with an event in the distant past but one that has been *ongoing* over those decades. In arguing for the distinction between external (observable) and internal (experiential) time fields Delisle places the distress of the recurring trauma on the internal level and the historical event on the external. In learning to recognize these multiple time frames the client is able to reduce the 'experiential dissonance' between them. This supports differentiation as opposed to generalization.

Differentiating experience

Trauma victims' tendency to generalization is a polarity that needs to be addressed in therapy. When life is organized through the lens of trauma there are few alternatives available, and the sense of self is diminished. By excluding parts of the field other than those related to trauma, awareness becomes diffuse. The ability to differentiate aspects of experience and therefore of self is prized in Gestalt therapy, which offers many ways of approaching it. For the Gestalt therapist, this differentiation happens most clearly at moments of good contact, in the meeting between self and other at the **contact boundary**. This happens by means of forming clear and well-supported figures.

In addition, many Gestalt therapists work to enrich the experiential field of the client by attending to three zones of awareness (Perls 1969). The outer zone includes aspects of the current field, both concrete and abstract. The inner zone relates to sensations, physiology, movement and impulse. The middle zone is that of thoughts, imagination, representation and dreams. We can learn much about how clients organize their experience by studying their zones of awareness. Trauma clients tend to overemphasize the inner zone of awareness, which keeps them on the alert for signals of danger; their middle zone is full of ruminations, intrusive memories and trauma-related conclusions about themselves and others, while they tend to have difficulty turning their awareness to the outer zone *as it is now*, as the vignette above illustrates.

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Experiment

Let your attention settle on anything in your outer zone of awareness, becoming aware of some of its features or qualities. Now bring your attention to whatever inner experience it is drawn to, a sensation or posture perhaps. Taking your attention back to your outer zone of awareness, begin to shuttle between the two zones. Try doing this for some minutes. Then ask yourself, 'What thoughts or images go with these zones of awareness?' They may or may not be related; it is more important to notice them as they are than to try and make connections between them.

Trauma theory helps therapists to recognize clients' recurring trauma-related symptoms as memories belonging to the past. It is much more difficult for clients to recognize this; we do not share a felt reality about this perception. Kepner underlines the necessity for trauma clients to differentiate the present from the past (1995: 89). In particular, these clients need to understand their sensations, body memories, flashbacks and other intrusions as memories and not actual current experience. From the client's perspective, triggers occur in present time and create a bridge to the past which must be dismantled.

A similar position can be taken in relation to past and present as to zones of awareness. By developing what Rothschild has named 'dual awareness' (2000: 129), clients can begin to shuttle their awareness between different fields of time. This act of differentiation can open the experiential space enough to allow for the processing of the trauma, because it is no longer so immediate and experience-near. As opposed to triggering escalating trauma-related thoughts, sensations and emotions about impending danger 'the act of mindful exploration facilitates dual processing' (Ogden et al. 2006: 169). In order to counter the natural tendency of trauma clients to become fixated on the past, therapists need to favour working with here-and-now awareness.

Awareness of the here-and-now

Gestalt therapy takes a clear philosophical and existential position in relation to the here-and-now. According to Perls, '*There is no other reality than the present*' ([1947] 1992: 104, original italics). Therefore Gestalt therapists consider that everything they need to work with is present in the room. Parlett's Principle of Contemporaneity (1991) is consistent with

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this: we can only turn towards the past from the viewpoint of each unrepeatable and consecutive present moment. Heraclitus's dictum that we can never jump in the same river twice is apposite. This is an important principle underlying Kepner's Healing Tasks Model (1995: 8). As the pressing needs of trauma clients are reworked over the course of therapy they are always approached from the here-and-now. There is thus a link between the dominant needs which determine figures of interest (Chapter 3) and the experience of the present moment.

In the opinion of Perls et al., awareness is a figure against a ground ([1951] 1998: 416), specifically our perception of that figure and ground. Gestalt therapists are interested in the quality of perceptions such as contact, sensing, excitement and wholeness which are all important factors for trauma clients. Wheeler considers awareness to be an act of organization (1998: 87), and as such has integrative potential, correlating to the window of tolerance. 'Awareness is . . . an emergent pattern of neural integration across all the levels of the interoceptive network' (Fogel 2009: 59). There is a process involved in awareness: it is an act of which the self is an agent. Furthermore, the awareness that derives from lively figure formation is present oriented. Awareness, regardless of its content, is a slice of time.

In the here-and-now of the therapy setting, we can help to increase clients' awareness of the present moment, and the rich processes and meanings that it contains. We may do this many times in a session – multiple individual aware moments. Using an understanding of resources and regulation, however, *we must avoid developing awareness of trauma-related content*. Awareness involves a temporal component, an experiential fragment and an 'I' who is experiencing. The gradual accretion of aware experiential moments thereby supports a growing sense of self that cannot pertain to unaware states. However, it is also extremely important for trauma clients to restore a sense of the continuity of their experience over time. The concept of the **awareness continuum** is helpful here: that one experience flows into the next and the next and the next, in an unending sequence of the flow of life. Clarkson describes following the awareness continuum as one of the most important skills a client can acquire: 'It may appear a very simple process, yet in many ways may take a lifetime to learn' (1989: 79). The phenomenological approach, which puts the experiencing self of the client at the centre of the work, is ideally suited to this purpose.

Awareness and the phenomenological method

Mackewn speaks of the 'development of awareness through a sustained enquiry into clients' subjective experience' (1997: 34). The term used for the subjective component of awareness is 'phenomenology'. This refers to

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the investigation of phenomena – units of personal experience – as developed by Husserl and other existential philosophers such as Merleau-Ponty. From phenomenological reasoning, Husserl derived a methodology for working therapeutically (Spinelli [1989] 1998: 2) which is a companion to the development of awareness. Phenomenology is one of the cornerstones of Gestalt theory and practice. This approach eschews the interpretive in favour of the observed – by either client or therapist or both.

The advantages of the phenomenological approach are numerous. There is a rightness in privileging subjective experience over imposed perspectives for those who have been objectified during trauma or by medical diagnosis. Of particular relevance to these clients are the neutral and non-judgemental stance it fosters, the containment of being held in a discrete moment of time and the fact that the amount of stimulus calling for attention is limited. The phenomenological approach is also an entry point into direct, lived and embodied experience, so often deadened by traumatic experiences. As Romanyshyn comments, 'the task of phenomenology is to loosen the grasp of the pre-conceived' (2007: 89). Gestalt therapists usually refer to the felt sense, as opposed to the 'aboutism' of cognitive processes. By means of the phenomenological method, implicit learning and assumptions – the fixed gestalts of trauma – are challenged and made explicit. There is a shift from the known to knowing, the formation of self-in-process.

There are three strands to the phenomenological method: bracketing (sometimes referred to as epoché), horizontalism and description. Each of these denotes a therapeutic attitude, and it is useful to recognize how, through the modelling of the therapist, trauma clients might learn to use these elements of phenomenology on their own behalf; we will return to this point shortly. Bracketing refers to the ability to set aside prior assumptions and knowledge in order to meet the client and their concerns afresh in the here-and-now. In seeking to regulate arousal and to reorganize the experiential field, we have already noted the need for the client to 'drop' trauma-related material and turn to other aspects of their experience; this is bracketing. It involves the *deliberate and choiceful redirection of attention to other possibilities in the field*. Horizontalism means paying equal and even attention to phenomena as they arise, without attributing particular significance to any one. There is a position of neutrality that can be achieved through this means, taking some of the heat out of charged material. The use of this for uncoupling of trauma-related associations and generalizations by means of here-and-now awareness is evident. Description is a therapeutic account of what is observed, the act of noticing. For clients this can offer the possibility of being with discrete elements of their experience.

Description has an important role in the development of an observing self, the capacity to stand back from their experience and be reflective

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rather than reactive. What is being argued here is the case for healthy **egotism** in the service of reorganizing experience, regulation within the window of tolerance and being more present to current reality as opposed to the past. However, Philippson cautions against awareness that creates understanding that remains on a verbal rather than a 'gut' level, involving a mere 'verbalisation of the sensation' (2001: 98). These two positions describe the tension between the Paradoxical Theory of Change and the step that needs to be taken by trauma clients in preparation for this to be effective. Consistent with the Integrated Model of Change proposed in Chapter 2 both positions are relevant in working with trauma at different stages of the work – taking a step back from direct experience first in order to be able to later step towards it in a more organized and supported fashion. Phenomenological description, tracking and enquiry are necessary for both steps.

Phenomenology and the body

For example, how do individuals inhabit their sadness, longing, satisfaction or their attachments? How do values and beliefs take their place in our being? What is the shape of shame, the quality of helplessness, the energy of 'Stop that!'? How much of our core supports our posture and movement? These deeply personal questions exemplify the essence of the phenomenological approach, and point directly to the lived body. Kepner suggests that early trauma disturbs 'the process of fusing consciousness to matter' (2002), meaning that we must reconnect awareness with body. Developing this theme, Merleau-Ponty distinguishes between 'having a body' and 'being a body' ([1945] 2009). Kennedy calls the lived body '*the body that is me* . . . my total self as I respond to the world which is with me in unending dialogue' (2005: 110, original italics). Further, he considers that the 'layer of living experience . . . is the level of perception [that is] subverted in trauma' (Kennedy 2005: 109).

In literal ways, because of the physiological impact of trauma, it is through embodied life that trauma becomes timeless. Our histories are encoded in our tissues, skeletons and nervous systems. Bodywork therapists intervene by directly affecting those tissues; however, their interest is not in the self of their clients as psychotherapists understand it. Just as we cannot heal trauma without integrating the body, psychotherapists cannot do integrative holistic body work without a phenomenological approach, that which includes the self.

By supporting an individual's increasing awareness we affect their entire organism. Kepner comments that conscious awareness has energetic properties (2002). We can take this thinking literally. There is empirical evidence to show that skin temperature rises from the moment that attention is given to a particular area (interview with Alexander, in Johnson

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1995: 286). Blood flow is increased and nerve endings are enlivened over time, which can support awareness of sensation and fluidity of process. For trauma clients we do not just seek to support awareness of sensation as a precursor to clear figure formation, although this is of great importance: 'One role of the senses in our daily lives is to wake us up, to pull us away from automaticity, to sharpen the acuity of awareness so that life is both richer and more present in the moment' (Siegel 2007: 77).

As well as difficulties with the sensation stage of the cycle of experience, many trauma victims have difficulty mobilizing, gathering energy to support action and contact. Trauma theory helps us to make sense of this and a fuller discussion can be found in Chapter 7. For now, however, it is worth noting that Perls had clear views about the importance of energetic movement, in the sense implied by **mobilization**. The term Perls used to denote the ability to take action is '**aggression**' ([1947] 1992), the engagement of the self at the boundary with other. Sensation alone will not suffice to bring about this movement towards the world. Kepner speaks of movement (including vocalization) as having 'the ability to expand and recover the full range of organismic functioning and to reverse the direction of retroflective muscular effort from the self back onto the environment' ([1987] 1999: 155). Here, then, is an earlier Gestalt formulation of the relationship between sensation and movement as is also inherent in Sensorimotor Trauma Therapy (Ogden et al. 2006).

Phenomenological tracking is a method of following subjective experience as it emerges over time; it is related to the awareness continuum. In tracking experience the trauma client is enabled to develop their awareness of their experiencing self, including repeating patterns, and to make links such as 'when I remember this I also feel this way and it is accompanied by these thoughts'. The technique of tight therapeutic sequencing (Polster 1991) supports the ability to 'stay with' a figure over a sustained period of time, allowing the client the opportunity to dwell in an experience and assimilate it rather than deflect from it. Gestalt therapists understand this as experimenting with 'directed awareness'. Sensorimotor Trauma Therapy adds an edge to this approach, by encouraging the client to *attend to the smallest possible units of experience over the longest possible stretch of time.*

According to Stern, the present moment has a duration of between 1 and 10 seconds, the unit of time needed to reorganize experience and make it conscious (2004: 41). It takes longer than this, much longer, for experience to be incorporated into an individual's being. Thus the phenomenological approach can be employed in the service of the finest possible calibration of arousal at the margins of the window of tolerance. Many trauma clients already know how to do this, for their sensitivity to danger keeps them acutely alert to changes in their inner zone of awareness. The observational skill of hypervigilance can be more healthily transformed into the ability to track and stay with a wider range of possibilities.

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Furthermore, the Sensorimotor approach is interested in developing trauma clients' awareness of particular sensations which are the precursors to movement, those impulses to 'aggress' in the sense Perls intended, which are so often **retroflected** or held in the body's relationship to the past.

Experiment

Start in the middle zone of your awareness by thinking about your feet. What attitudes do you hold towards them? Perhaps you will want to look at them. Do any memories or images come to you as you do so? Now, in the inner zone of your awareness, let your attention come to your feet. Become aware of the feel of your sock or shoe and the contact of your feet with the ground. Direct your awareness to investigate whatever sensations you notice – heat or cold, pressure or tingling, pulsing or aching. What are the qualities of the tissues in your feet – airy or dense or weak? Try to become aware of the dimensions and volume of any sensation you notice. Notice also any differences between your left foot and your right – the two sides of our bodies are asymmetrical and therefore unlikely to feel the same. Does anything change as you pay attention in this way? Really try to get a felt sense of each foot. Having done this, 'let your feet themselves be aware'. This is quite different from directing awareness into a part of the body. What do your aware feet experience? You can repeat this experiment by bringing your attention to different parts of your body. Write about the differences you noticed.

Awareness, phenomenology and the process of change

The emphasis in Gestalt therapy is on using awareness and the phenomenological approach to establish a full sense of 'what is' in current time, without effort to judge or to change. The Paradoxical Theory of Change is exactly this: change follows when we do not try to be different but instead fully accept how we are. This brings us to an apparent contradiction in terms of the Integrated Model of Change proposed in Chapter 2. There it was argued that for trauma clients the Paradoxical Theory of Change cannot apply without some preliminary steps being taken. In order to resolve this present contradiction, it is important to understand the sequence of steps that are necessary to support the Paradoxical Theory of Change.

The steps are specifically about the journey into deep embodiment. The problem for trauma clients is that they lack the neurobiological functioning to be able to claim their embodied existence in present time,

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which challenges us to revise our understanding of the change process. Orange uses a helpful metaphor, apposite to trauma clients' experience of their bodies at the outset of therapy: 'It is . . . like finding oneself in a strange house that is supposed to be one's home' (2010: 65). The task of trauma therapy is to help relocate clients into their current embodied experience of self. There is no clear point at which the Integrated Model of Change gives way to the Paradoxical Theory of Change; they are meshed together (see Table 5.1). In keeping with Kepner's Healing Tasks Model, there will be times when one paradigm for change is emphasized more than the other. In a non-linear process there is a gradually growing capacity for most trauma clients to learn to tolerate their current lived experience.

The inherent paradox is that the phenomenological method of raising self-awareness is both the means and the end result of taking this sequence

Table 5.1 Matrix of concepts

Stage of Embodiment	Process of Change	Kepner's Healing Tasks	ANS Arousal
Functional body	Integrated Model of Change	Support and Self-functions	Dysregulated arousal – hyper- and hypoaroused; fixed gestalts; polarization and limited choice
Desensitized body			
Thinking about body			
Awareness of body	Shuttling between Integrated Model and Paradoxical Theory of Change		Moments of dyadic regulation; some choice
Body as possession (I have a body)			Moments of self-regulation; loosening of gestalts; expansion of choice; increasing differentiation
Felt sense of body	Paradoxical Theory of Change	Undoing, Redoing and Mourning	
Body as self			Reliable dyadic and self-regulation; reliable resources; spontaneous gestalt formation; integration
Lived body		Reconsolidation	

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of steps. We cannot get anywhere without going there. More accurately, we cannot do something without learning to do it. According to Kennedy, the phenomenological approach can be learnt: 'phenomenology is only learned by doing' (2003: 78), and it is not just the domain of the therapist, though the therapist is a necessary teacher of the method. This is what is implied in the first steps of the Integrated Model of Change. Perls called Gestalt a 'concentration' therapy ([1947] 1992), and it is clear that concentration can be trained. Learning any new skill requires discipline and much repetition in order to integrate at an embodied level.

Just as the body needs exercise and training to become fit and healthy, so does the mind. Posner takes this analogy further by suggesting that attentional training can strengthen the psychological 'immune system' (2009, in Fulton et al.: 14). By this we can infer that a degree of resilience accompanies the optimal arousal of the window of tolerance. This point is of crucial significance in working with traumatized clients: that working phenomenologically needs to be *very repetitive and very consistent*. Requiring intensive and sustained attention to the minutiae of the client's experience, it is in addition *painstaking and demanding of infinite patience* in the therapist.

The role of mindfulness in trauma therapy

In recent years there has been an upsurge of interest in the benefits of mindfulness in helping people with a range of health difficulties, from depression to OCD to working with chronic pain. Research programmes and courses for the public abound. In some respects the concept of mindfulness is difficult to distinguish from that of awareness: a simple definition of mindfulness is 'awareness of the present moment'. To a certain extent the differentiation between the concepts is a matter of semantics, but not entirely (Fulton et al. 2009). While it is true that these are nested concepts, there are also some differences that are worth considering.

Yontef outlines four stages in the development of awareness, the two most relevant to this discussion being the difference between 'simple awareness' (it's a chilly day) and 'awareness of awareness', by which he means phenomenological awareness of processes and 'development and refinement of the tools of awareness' (1993: 280). Siegel uses the same term to explain this: 'awareness of being aware is the difference between awareness and mindfulness or mindful awareness' (2007: 16). Yontef understands awareness as a content and a process (1993: 150), while mindfulness is somewhat different. Mindfulness implies an ongoing process of aware noticing which is not so clearly flagged as an active directed conscious process in the Gestalt concepts of 'awareness of awareness' or the awareness continuum. Because mindfulness allows us to dis-identify

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with our thought processes, the arising awareness takes us a step beyond phenomenology.

Mindfulness is a modern derivation of the ancient spiritual practice of meditation, typically but not exclusively Buddhist. Perls was influenced by Eastern religions which probably informed his view of present awareness (Clarkson and Mackewn 1993: 18). The word mindfulness implies simple yet profound ideas. It is a particular kind of awareness, usually referring to a meditative state of open and alert attention, but we can also consider that the sustained attention of directed awareness induces a mindful state. It therefore can comprise properties of micro-attention as well as meta-perspectives.

Siegel considers that this meta-cognitive function is important, because it offers multiple perspectives on experience (2007: 242) that can enable the loosening of fixed gestalts. Fonagy further links this metacognitive perspective to safe relationships and to the development of resilience (2002: 79), consistent with the window of tolerance concept. Compare this to the important process of (simple) awareness in figure formation; in mindfulness we are not concerned with processes, actions or figures per se, but with a state of being. Mindfulness is always embodied; the knowing that derives from mindfulness involves neither insight nor any mental processes, unlike awareness or attention. A further distinction is that simple awareness does not necessarily involve the settling of arousal – indeed it may be disturbing – while mindful awareness is invariably calming and requires a sense of letting go. However, as Perls et al. caution, forced relaxation is as unsound as forced concentration ([1951] 1998: 76).

Fulton argues that the most transformative and liberating feature of mindfulness is that it changes 'our *relationship* to experience' (2009: 16, original italics). The relevance of this to trauma therapy is implied by Kolodny: 'To the degree that the meditative practitioner can be successfully mindful – present for the exact experience of each succeeding moment and not lost in thought of past or future – then for that interval there is no suffering . . . So *being present* provides a sanctuary from mental afflictions' (2004: 94, original italics). This is not always the case, but is an important possibility. Once a trauma victim has reliably learnt mindfulness as a means of taking the edge off their suffering a further development is facilitated by the practice.

A sense of compassion frequently results from repeated and sustained mindfulness practice. Buddhist meditation practice includes mindfulness of suffering which seems to naturally evoke compassion for the suffering and the self who suffers, accompanied by a sense of compassion for others. Mindfulness practice brings with it a deep sense of connection, consistent with a self/other orientation. 'Concentration, the mindful immersion into the given moment, ultimately leads to an expansion of the self, to opening and connection' (Bocian 2009: 54). It is therefore

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unsurprising that Brownell considers mindfulness to be ripe for assimilation into Gestalt therapy because it is so similar (2012: 99).

Mindfulness and the brain

One important finding of research into mindfulness is that it has profound effects on the function of the brain, as does trauma. 'An understanding of the roles of nonfocal attention and focal attention in the differential encoding of implicit and explicit memory can not only help to understand the impact of trauma on the mind, but also can lead to new strategies for clinical intervention' (Siegel 2012: 7-4). In Chapter 2 we described the role of the limbic system of the brain in the heightened responses of trauma. Neuroimaging techniques have demonstrated how fearful conditions alter the activation of the prefrontal cortex in particular, which Ogden et al. consider is partly responsible for the 'timeless' nature of traumatic memories (2006: 149). They suggest that the significant contribution of mindfulness to trauma therapy is because it *re-engages the prefrontal cortex* 'in support of observing sensorimotor experiences, rather than allowing these bottom-up trauma-related processes to escalate and "hijack" higher level information processing' (2006: 194).

This thinking is consistent with that of Siegel, who proposes that simple awareness does not involve the same regions of the cortex that are concerned with mindful awareness (2007: 144). It is suggested that the medial prefrontal cortex is activated by simple awareness. Siegel argues that it is regions located in the mid prefrontal cortex that are 'likely active during mindful practice and grow and strengthen their connections as a consequence' (Siegel 2007: 213–14). By this token, we can understand that simple awareness is not enough to create a state of integration in the brain. Through training in mindful awareness, '[r]etraumatization is minimized because the pre-frontal cortex remains "online" to observe inner experience, thus inhibiting escalation of subcortical activation' (Ogden et al. 2006: 195). Mindfulness has an associative function in the brain, rather than dissociative.

Thus mindfulness of the present moment has an important part to play in regulation of the ANS. Perhaps not surprisingly, the regulation of sympathetic and parasympathetic activity of the ANS is located in the mid of the prefrontal cortex, bringing about a state of 'nonreactivity' (Siegel 2007: 213). Access to feelings of well-being is also made through mindfulness, because it increases activity in 'areas of the brain associated with positive affect' (Davidson et al. 2003, cited in Ogden et al. 2006: 169). This underlines the reason for the slow and mindful development of resources and the expansion of choices within the window of tolerance.

Trauma impairs the integrative capacity of the brain, and mindfulness is a primary tool for restoring it:

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> [M]indful awareness practices may also provide integration of consciousness changes because these exercises catalyze awareness of awareness and attention to intention . . . through a process of internal attunement the observing self attunes to or focuses attention in an open and receptive manner, on the experiencing self. This internal attunement creates and amplifies states of neural integration.
>
> (Siegel 2011: 41–5)

One reason for this is that myelin, the protein sheath that permits smooth and rapid transmission of impulses through nerves, is increased by the practice of deep awareness – the energetic properties of awareness change the body.

Introducing mindfulness to therapy

Mindfulness training can consist of specific structured exercises, spontaneous emergent experiments and exposure to nature – access to resources (Posner 2009, in Fulton et al.: 14). Because of the immediate advantages of bringing trauma clients into the regulation of the present moment, and the long training that developing mindful awareness requires, it can be helpful to clients to practise regularly outside of therapy sessions, even though this is not standard Gestalt practice. They might access a mindfulness training course, usually eight weeks long, or one of the many available resources that can be bought on CD or downloaded via the internet. Certainly, access to nature and immersion in positive resources is invaluable and to be encouraged.

However, within the therapy session itself there will be countless opportunities to respond to emergent process with the use of mindful interventions. According to Ogden et al., mindfulness questions are those which 'discourage discussion, ordinary conversation, and brooding about past or future experiences' (2006: 194). Particularly in the early stages of the therapy, trauma clients lose their window of tolerance and their here-and-now focus over and over again. It is the job of the therapist to invite the differentiation of experience in the here-and-now. A principal therapeutic stance that can be fostered is that of curiosity about current experience. The ubiquitous Gestalt intervention 'What's happening now?' can be made more nuanced by asking 'Would you be interested in exploring what happened just now?' Phenomenological observation, naming a change that has been noticed, can be used to increase the client's self-observational skills: 'Did you notice how you did that? There's no need to change it, just stay with it and notice what happens next.'

Gestalt therapists are trained to facilitate awareness of processes that lie beneath the content of a story or talking 'about' something. They might

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comment, 'As you are telling me about your father, I notice that you clench your fist', or ask 'What feeling goes with that thought?' directing awareness towards something specific. Ogden et al. helpfully describe this as studying 'the *effects* of our speaking on internal experience' (2006: 194, original italics). Clients can be asked to 'drop' a level of awareness, from observing to the felt sense. These are all entry points to states of mindful awareness, which can be expanded and deepened. This is done through sustained enquiry and observation over time and immersion into the microscopic phenomenological experiences that comprise ongoing moment-to-moment existence. As one client observed: 'It's a skill – to sit and wait and watch, to not jump up and drive myself into action, it's clearer to me what to do'.

Summary

For many trauma victims time does not heal. Trauma severs a sense of continuity and of self over time. The past breaks through into their present experience not as capsules of ordinary memory but as vivid, visceral and recurrent intrusions outside the window of tolerance. These are fragmentary and discontinuous reminders of events that destroyed the victims's world view; they feel as real and present as though time had not moved on. These are bodily imprints of the past, even where clients are unable to differentiate the somatic elements of their current reality. Gestalt therapy focuses on here-and-now process, however we cannot ordinarily separate the past from the present – we look back from where we are now. We work to help clients understand that their bodily reminders are not present reality, a process known as dual awareness. This can only be considered from within the window of tolerance.

Awareness of the present moment is a key feature of Gestalt therapy. This is the process by which a reorganization of figure and ground can take place, and a sense of self emerges. By stretching awareness over consecutive 'present moments', continuity and fluidity replace the fixity and fragmentation of experience. The phenomenological method enables the study of embodied subjective experience in ways that are safe and tolerable for trauma clients. Simple awareness can give rise to mindful awareness, a state of being that can help to change the client's relationship to their experience, including the past. It also permits the sense of being able to inhabit the embodied self. Research into mindfulness suggests that it helps to create necessary changes in the brain which can reverse the impact of trauma. Developing mindful awareness is an important route to change, consistent with the Integrated Model of Change.

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PART 2
At the limits of self

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6 From fear to safety

This chapter explores the phenomenon of fear which for most people who have suffered severe trauma is all too experience-near. It considers how fear is present in the triggers to unresolved traumatic states, avoidance and intrusions. The orienting response to danger is discussed. The chapter goes on to explain the neurobiological basis of fear systems, and links are made to the instinctive survival defences that operate under conditions of extreme threat. The chapter concludes by describing ways of working to establish internal and external safety, illustrated by the first part of an extended case study.

Fear dominates the lives of many trauma victims. We have seen in Chapter 3 how the experience of trauma can result in creative adjustments that are more or less predictable, rigidifying or loosening structures within individuals. Familiar features of PTSD reflect the fear of such individuals, evidenced by hypervigilance and avoidance. It is through these behaviours that fear becomes an organizing principle for trauma victims. For many, it is not simply a recurring fear of bad things happening in the external field that is a cause of massive anxiety. Their internal world, somatic experience and felt sense also become a source of terror. Mental images, flashbacks, nightmares, intrusive ruminations and failure to discriminate between past and present add to the picture of fear that feels global.

Bromberg contributes a valuable differentiation of fear in trauma. Revisiting Freud he points out the difference between a 'danger situation and a situation that actually becomes traumatic' (2001: 169). He considers fear to be a natural response to danger distinct from the experience of psychological shock which, containing 'a generalised flooding' of feeling is definitive of trauma. Historically, one of the first ways of describing what we now call PTSD was 'shell shock' (van der Kolk et al. [1996] 2007b: 48). We might well call it 'post-traumatic shock disorder'. Closely aligned

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to fear is a sense of panic. To experience fear under threat is adaptive because it elicits alertness and caution (Soloman et al. [1996] 2007: 107). When the sense of threat and horror become embedded in memory, fear is not proportionate to the current situation and contributes to the development of PTSD (McFarlane [1996] 2007: 172). The experience of chronic fear brings with it an abiding sense of vulnerability and poor capacity to cope.

Avoidance, triggers and phobias

Put most simply, a trigger can be anything that evokes a change of state. Maybe you are sitting in your garden reading this book when a butterfly lands on the page. That moment of delight which re-directs your attention is a change of state triggered by the butterfly. If, however, you have a phobia of butterflies, your reaction will be rather different. Either way, the butterfly has caused your attention, and with it your emotional and physiological state, to shift. It is important to understand in trauma therapy that triggers can be positive as well as negative, and that what for one person is pleasant or neutral may for another be a source of terror. Triggers are more or less problematic according to the meaning we make of them, and are highly subjective. Underlying all triggering experiences is the linkage, or association, that is made to a traumatic event or situation. Clients will associate the trigger with a perceived present danger and not with an event that has already passed. Jacobs observes that we know from gestalt studies of perception that danger is perceptually vivid and paramount (2012: 65).

Trauma clients live in a world of triggers. For most victims triggers elicit dysregulated arousal, an automatic defensive response or both. It is not unusual for people to avoid returning to the scene of a traumatic event, sometimes going to great lengths to circumnavigate particular places. They come to believe that the scene of an accident, for example, is dangerous, when it is simply a symbolic representation associated with past danger. In the recursive, unfinished situation of the trauma response, the location, which is not dangerous per se, becomes feared. Others will avoid representations of violence for example, in films, on television or in print. While for most people knives and guns (and in our society, unattended packages) are rightly to be feared, countless objects which are intrinsically benign – almost anything in fact – can become linked in some way to a trauma and later avoided. Smells, sounds, facial expressions, physical characteristics, speech patterns and accents are just a few among countless possible triggers.

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Some cues are very subtle. One client came to a session on a sunny afternoon. He was already highly aroused by a nightmare the previous night and had found the journey to the session particularly difficult. The sunshine emerged as a figure in the session, and the client made a link to his service in sunny Iraq. This client had not previously been distressed by sunshine and in this case the ground for the trigger was the nightmare. Triggers can therefore be seen as state dependent. Things experienced in one environment, or state, are recalled when that environment is reinstated; this applies equally to 'internal' states as it does to 'external' environments (Eliotson 1835). State dependent memory may account for the common experience in which trauma clients are unable to remember the content of the previous session (Bromberg 2011: 77).

Reminders of trauma are often stored in implicit memory and not consciously recognized as belonging in the past. What is also likely is that what the individual most fears is not the external stimulus but the internal state of intolerable arousal. *The actual threat in the here-and-now is that of overwhelm to the autonomic nervous system*. As Roosevelt said in his inaugural address, 'The only thing we have to fear is fear itself'. Viewed this way, avoidance has as much to do with psychological survival as it does with physical. When clients have difficulty in knowing what sensations mean they may misattribute them, mistaking excitement for anxiety or calm for boredom. Such fear of experiencing anything can be very intense, because *any* internal somatic activation, even positive, is traumatically linked. It is as though the victim has the belief 'If I feel something I must be in danger'. Thus the external threat becomes internalized and the sense of the boundary between self and other is distorted.

Out of this background of fear, specific phobias arise. There is indeed much to be feared, and coming into therapy in itself may be triggering and elicit great fear. Being in therapy carries with it the risk of relationship, of contact, intimacy and of attachment, of reliving traumatic events, of vulnerability, of feeling feelings that have been disowned, of remembering what dare not be remembered, of knowing the unknowable, and speaking the unspeakable. Importantly, Kepner (2002) distinguishes *defensive* avoidance from the *incapacity* for felt experience. Many trauma clients have a great fear of reclaiming a body/mind that holds and mediates all of the above; of loosening the defensive structures that have ensured survival and of changing boundary functions. Bromberg (2001: 133) refers to Winnicott's (1974) concept of fear of the breakdown which has already happened. Clients sometimes indicate that they come into therapy because they 'can't go back there again' – to the place of collapse and disintegration. For others, talking makes 'it' – the traumatic past – more real, and while this is often experienced as helpful, it clearly has its downside.

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Responses to fear

Reflection point

Imagine that you have just left a cinema in a lively town centre at night, and are making your way to a bus stop. Your attention is suddenly caught by a disturbance caused by a sizeable group of very angry people spilling onto the street from a nearby pub. A fight involving many of them develops quickly and as some of them break into a run past you with others in pursuit, a shop window is smashed and bottles are thrown. You take cover in a shop doorway.

As you attend to the rapidly changing field conditions, what happens to your sense of embodiment? Take a moment to check if you are aware of how your body responds. Notice what happens in your arms and legs, to your breathing, to your heart rate. Does the temperature of your skin change; do you notice tingling or any other sensations? Do you have any other impulse to move? Do you notice any changes to your contact functions of sight and hearing in particular? What happens to your thought processes at this moment? Perhaps you notice a tendency towards chaos or rigidity, or both. Did you make a conscious decision to move into the doorway or did it 'just happen'?

Fear has intense visceral qualities. Keenan (1993) describes it thus: '[It] clamps onto me iron hard and will not let me go' (p. 64) and 'I felt my own fear claw out and crawl over my flesh' (p. 46). First, there is an abrupt and unexpected change of figure, the shock element. The sense of outer reality impinges on the contact boundary; redefines it too closely for comfort, and the sense of self/other becomes confused. In situations like this many people then recoil and become still, contracting muscles and making themselves smaller and narrower. It is interesting to note how completely the body corresponds to the situation. The drawing in and narrowing you may have noticed is an evolutionarily based response creating a smaller or less visible 'target'.

Fear involves a retroflection of energy, suspending the easy flow of movement. In order to stay alert the flow of fluids throughout the body is retarded (interview with Bainbridge Cohen, in D.H. Johnson 1995: 190). This outer stillness may be accompanied by an internal sense of high activation, while numbness is equally possible. There is a suspension of time. Other sensations you may have noticed in response to the above scenario would likely be signs of preparing to defend yourself either actively or

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through freezing, about which more will be said shortly. Individual responses will inevitably be shaped by personal history. Any thoughts present are likely to be a variant of 'I'm not safe', 'I'm going to get hurt' or 'I'm not in control'.

Hesse and Main have emphasized the role of unintegrated fear in the lapses in reasoning or discourse observed in the speaker (cited in Siegel 1999: 111). Generally, attention to the field reduces the sense of embodiment. Such compromises to availability for contact are profound and the neurological basis for this will be discussed below. For now, though, it is useful to consider that fear is also a regulator or moderator of contact. We can understand from this that when the experience of fear is pervasive the need for safety is primary and compelling. In the nervous system of the victim, safety becomes synonymous with survival.

Because of the vivid reliving of trauma as though it were in the present, fear and its associated manifestations become an organizing principle in the victim's life (Cozolino 2002: 251). It is as though the victim has an internal smoke detector which goes off when the toast is burning. It screams 'Get out! Get out!' when there is no real emergency. Porges (2003) uses the term 'neuroception' to describe a form of embodied dissonance, in this case a neural process that relates to both the environment and the viscera. He states that 'some individuals experience a mismatch wherein the nervous system appraises the environment as dangerous, even when it is safe' (2009: 46). It is this mismatch that reinforces and maintains the hypervigilance of many trauma clients. There is clearly a perceptual difficulty here, usefully summarized as False Evidence Alters Reality. Perls et al. describe chronic apprehensiveness as a '*mis*apprehension of actuality' ([1951] 1998: 30).

Orienting to danger

Trauma clients are frequently on the alert for signs of danger, which in this context refers to perceived danger rather than actual threat. You will notice an exaggerated startle response in some victims, who react to relatively low-key stimuli. Sensorimotor Psychotherapy proposes the orienting response as a way of identifying how a client organizes their experience. The orienting response goes hand-in-hand with hypervigilance, keeping the perception of threat and the sense of danger in the foreground of the victim's experience.

The body anticipates posturally what is going to happen, and this can be observed phenomenologically in the limbs as well as in the torso, leaning forward or pulling back. Hypervigilance comes in different guises; it can be generalized into health anxiety, restlessness, anticipatory anxiety, or marked impatience for a train to arrive. 'What we turn our

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attention to, or orient to, determines not only our physical actions but our mental actions as well' (Ogden et al. 2006: 65). Cozolino describes this response as a reflex (2002: 246), which is learnt from past experience. An example of this is illustrated by a client I will call Maria.

Clinical vignette

Maria lived much of her life with symptoms of severe dissociation. I noticed that she became particularly activated when her eyes moved towards the right. The first time I pointed this out to her and suggested that she tried turning towards the left, something small shifted, and she 'returned' sufficiently to the present to tell me that her childhood bedroom door was on the right. The following session, when Maria was standing in the room, I noticed a similar state switch accompanied by looking towards the right. Again I suggested looking towards the left, which Maria did, but this time, because she was standing, she was able to shuffle her feet round to the left, while keeping her eyes on the same spot. This aligned her head and torso habitually again to the right.

I then understood that it was not just Maria's eyes that oriented towards the perceived threat, but her whole body. The difficulty was not about looking – an external focus – but about the position of her head in relation to her shoulders. When Maria was sitting down again I suggested repeating the experiment, with a subtle difference. Instead of asking her to look *towards the left, I asked her* to turn her head *towards the left. Because in the sitting position she could not move her feet, this movement helped reorganize the familiar relationship of head to shoulders and torso. Maria immediately responded, 'Oh, I feel calm now, more stable'. (This story appears also in Taylor,* 2013.*)*

This vignette illustrates the somatic basis of the orienting response. Maria was orienting to an internal stimulus which clearly felt vivid and present to her; she literally was keeping an eye on threat. Implicit somatic memory (Siegel 1999: 28) was figural, and it was not necessary to work with the 'story' behind it in order to create a shift. However, had I chosen to explore the figure of the door, I imagine that Maria's dissociative difficulties would have been compounded and there would have been no therapeutic value at this early stage of therapy. Maria's focus of attention had narrowed and she seemed unaware of her current surroundings or of my presence; she was unable to orient herself instead towards 'cues indicative of safety' (Siegel 1999: 65). In orienting towards her experience of the

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door, Maria was physically and psychologically anticipating some aversive experience. By focusing her attention on a different experience, she was able to obtain new information about herself and her surroundings, permitting the emergence of a resource which interrupted her tendency to relive the trauma. In order to integrate this resource it was necessary over time to repeat the new orientation until Maria had learnt it and could use it for herself.

The neurobiology of fear

Fear is both an innate and a conditioned response to threat and danger. It is hard wired in us. Babies show fear in the presence of a loud noise or scary face even if they haven't experienced these before. For trauma clients the response is learnt or conditioned in the Pavlovian sense. LeDoux considers that the effects of this conditioning may be long lasting or even permanent. He says 'We have to learn what to be afraid of, not how to act afraid' (2002: 213). The brain is predisposed to associate fear with threatening stimuli but completely neutral or meaningless stimuli can have this effect too (Panksepp 1998: 215). There is a neural circuit in the brain which implicates the amygdala in fear processes (Panksepp 1998: 207; Damasio 2000: 61; Cozolino 2002: 242). The amygdala, which sits in the mid-brain, triggers the ANS and has branches to many areas of the body/mind. It is this distribution of branches throughout the body that explains why the response to threat involves visceral, sensory and motor elements, making the experience of fear a 'whole body phenomenon' (Cozolino 2002: 243).

The amygdala stores fear memories in its circuits and monitors the world for safety and threat. At the same time the hippocampus helps to evaluate and appraise the *context* of the danger, and contributes to the feeling that the traumatic event is ongoing (Rothschild 2000: 12). So, when you see a brawl on television or in a film you don't react in the same ways as you would if it were actually happening in real time in front of you. This is a neurobiological explanation for the figure-ground imbalance in traumatically generated fear: the response arises from a fear-laden ground without accurate appraisal of the threat. The site of these fear circuits in the sub-cortical area of the brain explains why we react to certain stimuli before we can think (Rothschild 2000: 239). It is important to remind oursleves that when an experience is limbically driven, the 'chatter' of the frontal cortex shuts down.

> [If] something attracts our attention and intrudes on our thoughts, we become more vigilant and concrete, shifting the balance of our

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> brain activity to subcortical areas to heighten our senses in order to detect threats. As we move . . . towards fear, then, we necessarily rely on lower and faster brain regions . . . our responses are reflexive and under virtually no conscious control.
>
> (Perry 2006: 49)

LeDoux describes the relationship between the frontal cortex and the amygdala, suggesting that each inhibits the activity of the other, the one keeping the other in check, and vice versa (2002: 217). When the amygdala is aroused it can modify the processing of sensory information in the cortex (LeDoux 2002: 227), and *increases emotional tone over cognitive function*. There are clear implications of this for therapy with trauma clients who chronically avoid triggers or are hypervigilant, or both.

There are both neuronal and chemical reasons for the changes in the brain as a result of chronic stress, anxiety and fear. Recall Hebb's Axiom, that neurons that fire together wire together. Stress re-activates fear circuits which have previously been laid down (Cozolino 2002: 247). Stimulated repeatedly over time, the neural pathways involved in fear become 'hyperpotentiated'. This means that the resulting degree of fear is bigger than the sum of the stimuli. Consequently, it takes a lesser stressor to reactivate the pathway (Cozolino 2002: 246). In addition, there are chemicals known as neuroactive peptides acting on the nervous system, an example of which are endorphins, released during stress or pain. These are released into neural circuits alongside a fast neurotransmitter when action is needed, acting within milliseconds. Neurotransmitters are chemicals which enable the transmission of cues from one neuron to the next.

Cortisol, which is a type of hormone released under stress from the adrenal glands, is another neurotransmitter which is key to information processing in the brain. It has a particular impact on the amygdala, increasing the intensity of fear reactions. Chronic release of cortisol has toxic effects on the body, and after time the adrenal glands become exhausted and cease producing cortisol. The result of this is that the protective function of cortisol is no longer available, and the individual is increasingly triggered by small stimuli. A further process is mediated by an amino acid known as GABA, which has the effect of 'guarding' the amygdala from turning on. Under some situations however, GABA is inhibited from causing the amygdala to respond to neutral or benign stimuli (LeDoux 2002: 57–64).

Chronic exposure to stress or trauma can result in damage to structures of the brain. This is particularly significant for those clients who have been subject to early abuse as well as those who live as adults in dangerous situations, such as war or domestic violence. There is a biological link between prolonged stress and reduced volume of the

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hippocampus, caused most likely by the presence of increased levels of certain neurotransmitters in the body. So, for chronically stressed clients, it is easy to deduce that their ability to use contextual cues in the appraisal of threat is compromised, and has a direct 'influence [on] the nature of emotional experience and emotion regulation' (Siegel 1999: 248). High levels of these chemicals in the blood stream produced by the endocrine system may also suppress the immune system and account for increased physical illness in some chronically fearful clients (Cozolino 2002: 251–2).

Survival-based defences

The need to defend ourselves from threat is also hard wired and inextricably linked with the need for survival. Defences are adaptive to circumstances so that we have a degree of natural flexibility in response which is field sensitive. Importantly, Cozolino states that under stress we tend to regress to more primitive defence mechanisms (2002: 247); by primitive he means subcortical. Defensive systems are closely related to the orienting tendency in that the field of consciousness is narrowed (Ogden et al. 2006: 90). No one defence is 'better' than another. In trauma victims the problem is one of inflexibility of response (p. 89). This inflexibility is the result of defence mechanisms becoming conditioned over time: 'When a defensive behaviour is successful, it becomes recorded as effective; the chance of the same behaviour being used in a future threatening situation increases. Likewise, when a defensive behaviour fails, the chance of repeating it decreases' (Rothschild 2000: 54). Once again we can see the repetitive quality that so defines trauma.

The relationship between fear and danger can lead us to assume that this carries with it the possibility of escape. Likewise, shock relates to life threat, with no chance of escape. What determines whether an individual develops a chronic trauma condition is not so much the degree of threat, but their *inability to complete a defensive manoeuvre*. The feeling of being trapped in a situation is very common among trauma victims. If someone is overpowered or trapped in some way the instinct to mobilize towards escape is truncated, and fight and flight defences give way to more passive ways of dealing with the situation.

Janet, writing in the early twentieth century said '[These clients] . . . have not been able to perform any of the actions characteristic of the stage of triumph' (1925: 669, cited in Ogden et al. 2006: 86). Along the same lines, Perls et al. write: 'It is a basic tendency of the organism to complete any situation or transaction for which it is unfinished' ([1951] 1998: 77). To quote Janet again: '[the clients] are continuing the action, or rather the attempt at action, which began when the thing happened, and they exhaust

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themselves in the everlasting recommencements' (1925: 663, cited in Ogden et al. 2006: 86). The inability to defend yourself from a life-threatening situation serves later to maintain trauma symptoms, deterring their resolution (p. 101). Clients develop the belief that they cannot cope with daily challenges which is related to generalized defensive responses (p. 87).

Fight and flight are active, mobilized defences, along with the instinct to reach or call out for others. The woman being raped cries out for help, known as the 'attachment cry'. In contrast to these mobilized defences are the immobilized defences of freezing and submission. Freezing involves alert immobility, rather like a rabbit in a car headlights, causing the driver to brake. Submission is a state of collapse with profound inhibition of motor activity, more akin to the mouse in the cat's jaws feigning death. These patterns, or combinations of them, show up behaviourally, physiologically and posturally in many trauma clients. Kim Hosier (personal communication, 2011) usefully summarizes these defences as the 'Five F's': Fight, Flight, Freeze, Flop and Friend. 'When the mobilizing defences have failed entirely or produced only partial success in preventing trauma, the person may become traumatised' (Ogden et al. 2006: 92). A sequence of defensive responses has been proposed (p. 98), as follows:

1. Marked change in arousal
2. Heightened orienting response
3. Attachment and social engagement systems
4. Mobilizing defensive strategies
5. Immobilizing defensive strategies
6. Recuperation
7. Integration

This shows that there is a hierarchy of defences and highlights the need to *reverse* the sequence in therapy where clients have become immobilized. Clients often experience flight impulses in their legs, but they can also be observed in 'twisting, turning or backing away' (Ogden et al. 2006: 91). Flight may be concerned with running towards safety or an attachment figure. Fight responses more typically involve the arms, hands and shoulders, narrowing of the eyes, jutting of the jaw or the impulse to kick or struggle (p. 92). Clinically, it is helpful to be able to track and to work with these phenomena.

Clinical vignette

Jan reported during a time of hyperarousal that she felt like running out of the room. I encouraged her to stay with the sensations that she

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noticed in her legs and to make running movements while she was sitting. She found these rhythmic movements helpful and she began to calm down. I then suggested that she made slow running movements, and then added a further stage to the experiment in which she slowly increased the speed and noticed the point at which she felt the impulse to run emerge. Her comment was, 'Oh! I feel much more in control.' This sequence of movements helped to follow her energetic charge while reorganizing it into something more adaptive, and to fine-tune her awareness of her process.

Ogden et al. observe that when hyperarousal accompanied by immobilization has been the habitual response to trauma, we often see arousal return to baseline through discharge and dissipation made possible by physical activity (2006: 101).

Risky behaviour

We will look in more detail at the helplessness of immobilized defences in the next chapter, but it is worth considering here that victims can experience analgesia as an important function of immobility (Rothschild 2000: 49). The inhibition of pain results from the secretion of opiates induced by *reactivation* of fear (van der Kolk and Greenberg 1987: 72). This may provide an explanation for why some trauma victims seek out dangerous situations, either deliberately or out of awareness. One young rape victim, for example, didn't think twice about accepting a lift from drunken strangers until afterwards. This is a complicated issue with no single explanation. Repetition compulsion can be understood as an attempt to complete the unfinished gestalt. It may be an attempt to relive and master the overwhelming feelings of the traumatic moment (Herman 1992: 42), or an act of bravado that preserves the integrity of the self – 'Nothing frightens me now' – and seeking stimulation can help organize sensation.

Bromberg suggests this: 'Around each corner is potential trauma; peace is simply the calm before the storm, and if he [sic] goes too long without verification of the reality of his dread, he needs to find some event that provides evidence that justifies his felt need for vigilance in a world of traumatic reality' (2001: 260). Another client complained that life had become too calm and pleasant: 'I know I should like it, but I need danger,' she said.

For some clients the risks are more subtle because their behaviour links to passive defences. According to Kepner, 'We all tend to seek environments that match the self-functions we have' (1995: 61). So, if a client

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hasn't yet learnt to establish clear boundaries, for example, they may adopt a victim role in the pejorative sense and be repeatedly taken advantage of by others. Particular consideration needs to be given here to victims of domestic violence. It is a popular misconception that these individuals should 'just leave'. However, taking into account the theory of mobilized and immobilized defences, the riskiest time of all in domestic violence is the point at which the victim asserts their power and begins to act, and most victims know this implicitly. Fear justifiably keeps them trapped.

Such risks need to be assessed and managed from the outset of therapy. Clinical experience shows that as a sense of safety develops and fear is less figural in a client's life so these risks diminish, but this can take a very long time. Clients begin to be more attentive to their regulatory behaviour when real alternatives are available. But for others, like the client needing danger, it is helpful to try to transform this tendency into healthy excitement.

Establishing safety

> Fear needs to be tamed in order for people to be able to think and be conscious of their needs. A person's bodily response of fear can be mitigated by safety of attachments . . . and by a body whose reactions to environmental stress can be predicted and controlled.
> (van der Kolk [1996] 2007b: 205)

This underlines the need for a body-based approach in therapy. Only if we feel safe *internally* can we engage actively with the environment and increase contact. This is because of the social engagement system and accurate appraisal instead of having to attend to a narrow field of experience. Of course it is difficult to control the external environment, but clients *can* learn to have some control over their internal state. Although many fear responses are hard wired, many are also learnt through conditioning as we have seen, which means that they can be modified.

Establishing safety is consistent with the first two stages of Kepner's model, where the development of self-functions goes beyond initial conditions of safety in therapy. The safety of the therapeutic frame is not enough for trauma clients. For Kepner, the key to establishing safety is through the body, but he cautions that this must be done safely enough for the body to become a resource rather than a 'privation of an adaptation that has had high survival value' (1995: 245).

Everyone needs to feel safe! A sense of safety is a basic human need. When we feel safe more spontaneity and choice is available to us. For

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trauma clients, safety can represent triumph over immobilized or incomplete defences. Safety needs not just to be understood, realigning appraisal capacity with current reality, it needs to be deeply felt and experienced. So what does it mean to feel safe? Some of the components of safety for trauma clients include being present centred, grounded and contained; the ability to regulate emotional states and accurately re-appraise current conditions, 'experiencing' functions (Kepner 1995: 78) and boundary functions being among the most important. Working with attentional shifts is necessary too, to enable new perspectives when attention is too focused, to be particular and discriminating when attention is too generalized, or to redirect attention away from triggers or towards the context, like changing the aperture on a camera. This requires some flexibility and a range of options.

Historically, a number of approaches to therapy with trauma victims have recognized safety as of prime importance. EMDR, for example, like Sensorimotor Therapy, has the idea of a safe place as a first step. The capacity to imagine can be a great asset in the early stages of therapy, which applies here. The usual way of establishing the safe place is to invite the client to picture a place, real or imagined, that feels safe. It is helpful to make some simple conditions: it must be somewhere they can feel fully their self; no one can make any demands of them or have any expectation of them; nothing bad can happen there. Therapists may need to be quite insistent about this last point using a little bit of creative 'magic' to ensure that the tree house can't fall down in high winds, for example.

With an emphasis on slow integration, therapists should work with each of the client's senses in turn to build up a detailed experiential picture of the place; for example, using the sense of sight to attend to textures, colours, shapes, light, movement, and similarly for *each* of the other senses. Bring in also the client's sense of their body in this place, including posture, interoceptive awareness, movement and emotional responses. Really linger with each component of the whole experience, making it as vivid as possible. Find out what it means to your client to have this place, with these conditions, and how they could make use of this in their daily life.

This approach to developing a sense of safe place is not appropriate for all clients. It is a top-down method that leads to embodiment. A more bottom-up way is to suggest clients choose a colour, sound or other experience that represents calm and to work to integrate it in a similar fashion. We need to encourage *all* the senses and modalities to build resources such as these because integration does not result from the activity of one system of the brain alone (Grigsby and Osuch 2007: 49). There is plenty of scope for creativity with this concept once you have grasped it. You are strongly recommended to try this for yourself.

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For one client an important feature of her safe place was the feeling of being 'held' by the chair from which she was looking out at her garden. I used this information diagnostically to understand something that was missing and needed, and worked in later sessions to enhance her experience of feeling held. At various times we explored through phenomenological investigation how she felt held by the chair in this room, how she held herself, how in some areas of her body she resisted being held, different qualities of holding, and so on. These felt experiences helped to counter her frequent times of panicked overwhelm, when she felt unable to contain her strong emotions. The feeling of being held relates closely to environmental support and the basic function of yielding (Frank 2001). Many trauma clients have chronically over-bounded musculature, a problem with yielding, developed in the belief that nothing external can be relied upon for support and therefore that they must manage everything alone, and for this client it was also true that she couldn't manage it all, creating a somatic 'dilemma'.

A young client 'expressed' his extreme trauma in very poor concentration and abrupt disorganized movements. I did not find it easy to contain him. One time he was pacing the room anxiously and then lay down on the sofa. I quietly offered him a blanket and placed cushions all round him. I rested my arm gently across a cushion on his torso at which he quietened down considerably and began to put some words to his experience. I imagined that the extra weight gave him a clearer sense of his body. I could sense his capacity to think return.

Related to containment in so far as it involves yielding, is the sense of groundedness which is connected to particular areas of the body. This feeling is essential to our sense of presence, stability, continuity and connectedness. Again close attention to the minutiae of experience is helpful here, of the weight of the feet on the floor, the solid base of the pelvis and sitting bones, the relationship to gravity, comparing left to right, front to back, finding areas that don't yield so readily to the ground.

Kepner writes extensively about boundary functions (1995: 65ff) and readers are recommended to turn to his work. What needs to be stressed here is that again the *bodily* sense of boundary needs to be established. This needs to be at two levels. The sense of skin as boundary is important in relation to containment. The use of self-touch, holding different areas of the body can help, as well as work with the big boundary muscles of the body. Most important among these are the muscles of the back. Much of the distress of fear and dysregulated arousal is in the viscera, and drawing attention to solidity of the back helps settle this well. The second level of boundary which needs to be worked with is that of the interpersonal boundary.

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Experiment

This experiment is typical of Sensorimotor Trauma Therapy. Take some minutes to slowly mark out a boundary with your hands, all around you, including above and behind. Get a clear sense of how far out your boundary may need to be – and whether this is the same in all planes of your exploration. Really get a felt sense of what space you need and what it feels like. Most people do this with their hands raised in a 'Stop' gesture. This is protective and an active defence. You might like to put some words to this: 'This is MY space; keep out!' or whatever feels right for you. While it is important to be able to keep out unwanted intrusions, you may also notice that this is an isolating position. Flip your hands over, palms facing up, and compare your felt experience of this. Finally, try this experiment with one hand up and one hand in the stop gesture. What happens now? Do you get a sense of overbounded or underbounded? What is just enough sense of boundary for you and how can you tell? You can do this experiment with clients.

It is not necessary to be prescriptive about the kinds of experiments that are helpful in restoring a sense of safety through body awareness; the creative attunement and experimental attitude of the therapist is enough. What cannot be compromised, though, is the need for extensive slow and repetitive work in this area. Functions and perceptions involving subcortical areas of the brain take longer to develop than those involving cognitive capacities.

A crucial capacity trauma victims need to learn is to check out reality against those perceptions which have been developed in the context of trauma. If a client becomes triggered in a session it can be helpful to suggest they check around the room for any signs of immediate danger. This kind of question not only helps distinguish present from past, it integrates thinking and perception. It is most important to be able to accurately discriminate in this way, moving from guessing, which preconfigures the field, to *actual* experiencing (Kepner 1995: 96). By these kinds of means, traumatically linked associations with triggers can be decoupled over time. It is also valuable to invite clients to find something in the room that helps them stay anchored to the present, and to be able to focus on this when triggered.

Safety is a concept which is not accessible to all clients. Indeed, for some it can feel dangerous, implying that they must drop their hard-earned adjustments to a terrifying world. It is wise never to invite a client to relax. Instead,

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they can be encouraged to stay just as alert as they need to in this moment, allowing for some softening of the rigid polarity of constant full alert. This differentiation increases the sense of real control that these clients so desperately need and it requires learning to rely on sensory and interoceptive information, and relaxation may follow naturally. 'Safe' may be a word that has been used by an abuser and therefore its use may need to be avoided until it can be tolerated. Replace it with 'calm', 'peaceful', 'feeling quiet inside', so that you can develop a shared meaning. Some clients feel so bad about themselves that they believe they do not deserve good feelings and may perceive 'punishment' as something justified they have brought upon themselves. Yet others may be currently experiencing dangerous or abusive field conditions, such as domestic violence, and it is not really possible to begin trauma therapy with them until their situation changes.

Case Study Part 1

The background

Eve was in her mid-40s and working for a mental health charity when she came into therapy. She was a single mother with an 8-year-old daughter, Freya, from a brief relationship. The first story she told me was about her boss who was intrusive and bullying. He was looking at her work diary behind her back and cancelling meetings and groups that she had planned. Eve felt undermined and humiliated by this, as though the remit of her job was being changed without discussion. It seemed to Eve that there was a hidden agenda which confused her. As we began to explore this current relationship, Eve was able to start telling me about a trauma that she had experienced in her 20s. She had been working for a medical charity in a refugee camp in Kosovo. One day she went to meet someone to arrange the delivery of some supplies when she was taken to a derelict building by two men, held hostage and raped. It became clear that Eve's current work situation was triggering old material. Interwoven with these themes was her strained relationship with her parents and her difficulty in communicating her need for support effectively.

Eve's feelings about not being taken seriously by her parents began to make sense when she spoke of a difficult time in her childhood years. Her paternal grandfather had come to live with the family when Eve was 13 because he was developing dementia and could no longer live independently. A symptom of his dementia was his sexually disinhibited behaviour and Eve had been the main object of his attentions. Eve's mother had responded by becoming depressed and taking to her bedroom, while her father coped by laughing the whole thing off.

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Working with Eve

Eve's high level of anxiety when I first met her was of immediate concern to me. She sat tensely, seeming to have an unbalanced relationship to gravity as she tilted forwards and rested only her toes on the ground. She didn't stop moving her hands, eyes and head. Eve's voice was clear, unsupported by her shallow breath. I sensed a protectiveness in her crisp and efficient speech. She told me she felt abused and sorely lacking in protection. I didn't know why, but my felt response to her was a sorrowful but unspoken question, 'What on earth has happened to you?' I wanted to reach out gently, intuitively picking up that Eve was petrified.

As Eve told me of the desperation that brought her into therapy, feeling controlled by her symptoms, I registered viscerally that she felt unsafe in her work relationships, on the edge of feeling fear for her. It puzzled me as my feeling seemed bigger than her story, but I nevertheless trusted that this meant something that we did not yet understand. Because of this, and because it could do no harm, I chose to begin with talking about helping Eve to feel safe. When we looked at the window of tolerance map together, it became clear that Eve related to both the phenomenology of hyper- and hypoarousal. Most of all, the map made sense to her and that gave us the opportunity to negotiate the way forward. It seemed a good way to meet Eve initially.

Eve's emerging trauma provided me with some relief as I made sense of my strong reactions to her. She began to be aware of the many ways in which she was being triggered, and that in turn made sense of feelings and sensations that accompanied situations in her current life. Eve was sleeping poorly and reported that she often woke with a start, which distressed her though she had no recall of dreams. She was quite preoccupied with her relationship to her boss, feeling trapped and terrified of his presence, which she avoided often through taking sick leave when she was due to meet with him.

We worked consistently and carefully with safety, helping Eve to identify the feelings associated with her thought processes and finding ways of returning to a calmer state within her window of tolerance, by altering the focus of her attention, particularly using her safe place. While in the Balkans, Eve had dived off the coast of Montenegro and returned to the peace of that underwater environment in her imagination. I noted Eve's rapid glances at the door when she was hyperaroused, which I thought was her orienting response, imagining that she was being triggered in a closed space. I frequently worked to recover Eve's sense of where she was and her place in current time.

It was necessary to understand Eve's phobias, particularly of her pain and of body sensation. Eve had a recurring painful body memory

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which caused her to be fearful of approaching any charged topics. For her, learning to feel again might make the trauma real. Increasingly she was able to know for herself what she could and couldn't talk about and we discussed sometimes what might help her to feel more supported. In this way she was learning to recognize and manage her fears.

Eve invariably avoided busy situations like supermarkets, where standing in a queue brought her into too close proximity to others. She shopped at quiet times of the evening, even though this was not ideal for Freya. We worked on her sense of boundaries, and Eve had a great deal of difficulty in asking me to stop during an experiment in which I approached her slowly. She had no sense of her ability to say 'No' to me or identify what she needed from me. She developed the ability to ask me to have my chair at a certain distance from her and we worked with her phenomenology of this; she became acutely aware of any changes in my position; a more differentiated awareness. The concept of the boundaries of her own body, and of her skin as a container, was a complete mystery to her to begin with. 'Boundaries are out there', she told me. However, she began to get a sense of the difference that being wrapped in a blanket made to her, and she treated herself to a new fluffy throw to use at home.

I had to be quite clear with Eve that given the lack of safety in her ongoing relationship with her boss, there were limits to the work we could do. Safety needs to be both internal and external, and Eve understood this. One focus of our work over time was therefore what she wanted to do to change this aspect of her life. As a single mother, there were of course financial considerations to keep her in her job. She worried that the amount of sickness absence she had taken would be used against her in finding a new job. The idea of speaking up about her boss caused her to have panic attacks, based on a fear of him becoming violent, without any evidence for this.

Summary

Fear is a symptom which carries a story about past trauma and unfinished business. It is a major organizer of figure and ground in the experience of trauma victims. It carries with it elements of pervasive terror about both external and internal threat. The fear response in trauma clients is conditioned and may be state dependent. Because it has become generalized, as far as the client is concerned fear is related to current reality. It is a problem of perception in which past and present cannot be distinguished, leaving the client in a state of alarm. A state of heightened fear can be triggered by any object, situation, person or experience that is sufficiently reminiscent of the

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original trauma to have become associated with it. Clinically, fear presents as avoidance and hypervigilance as well as in postural, behavioural and physiological adjustments.

One consequence of fear is that clients tend to narrow their field of awareness, focusing on danger to the exclusion of other contextual cues. This tendency is referred to as the orienting response. The implication for therapy is that by widening or redirecting the focus of attention, new possibilities for orienting towards safety emerge. The orienting response is biologically driven, closely connected to survival instincts. Neural circuits concerned with fear and appraisal of threat operate in different areas of the brain, particularly in the amygdala and hippocampus, connecting to the ANS and the viscera. Coupled with these networks, chemicals related to stress play a significant role in the response to threat, and act very rapidly indeed. The hormone cortisol, which is produced under stress, is particularly concerned with responses to threat and under prolonged stress can be damaging to structures of the anatomical brain. The felt experience of fear involves the whole sensory-motor body/mind. These responses are not within conscious control, the integrative capacity of the cortex having become uncoupled in the process.

Once the orienting response has initiated an emergency reaction, survival-based defence processes take over. These can be grouped into mobilized defences of help-seeking, fight and flight, or immobilized defences of freezing and submission. In cases of extreme danger there can be greater survival value in becoming immobilized, which can de-escalate threat. These defensive tendencies become deeply embodied and re-emerge in the clinical setting when the client is triggered. It is an important task of therapy to help the immobilized client to reverse the process towards mobilization.

A further situation where fear may present is in clients who take risks. There are a number of possible ways of understanding this kind of behaviour, and they may co-exist in individual clients. There are important implications for risk management by therapists.

Learning skills related to safety is also survival based and is essential for recovery from trauma. These skills may begin with an embodied sense of a safe place to which the client may 'return' in memory when needed. In order to support emotional regulation and tolerance of internal experience, the ability to feel grounded and contained is invaluable. To do so requires the development of a range of somatic resources, built slowly and carefully over time. For some, though, the development of safety cannot be approached directly, and caution and less direct routes to the same end must be found.

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7 From helplessness to autonomy

The sense of helplessness is a very pervasive and implicit experience for trauma victims. This chapter looks at helplessness as a feature of immobilized defences both for its psychological impact and its embodied effects. In contrast, Gestalt therapy principles of mobilization and fluid process are considered. The chapter continues by exploring changes in interpersonal dynamics and the locus of control shift which alters the client's sense of self-and-other. Autonomy and self-agency are discussed, setting up an enquiry into how trauma clients can be supported to regain control over their own bodies and feel more powerful. The role of anger as a differentiating emotion is explored.

The relationship between fear and helplessness is very close. Overwhelming fear paralyses us; we become 'scared stiff' (Levine 2010: 49). To be overpowered or trapped means to feel utterly helpless. We literally do not know what to do with ourselves or which way to turn. We may not know that there might be something that could be done. There can be a loss of sense of volition and intention in the body, and furthermore self-concept as someone with agency is usually radically altered. Trauma victims no longer have a sense of control over their life and the immobilized defences of freezing and collapse are not appreciated for their survival value. More probably, clients will condemn themselves for not having taking action. So, the feeling of being helpless is often an enactment or repetition of the original trauma. Bromberg (2001: 302) recognizes helplessness as an inevitable though frequently hidden self-state of people who have experienced trauma, often seen in people abused as children or victims of domestic violence. A sense of helplessness is therefore one of the most pernicious effects of trauma.

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Helplessness and healthy process – a Gestalt perspective

It is implicit in Gestalt therapy that mobilization is privileged over immobilization because of its role in the healthy formation and completion of gestalts. Fluidity of process is a precondition for the creation of fresh, clear figures. An energetic charge supports the forming figure, building from sensate experience and pushing towards a peak at the contact point of the cycle of experience. The 'glow' of awareness (Perls et al. 1951: 75) translates into an impulse which may be thwarted, limited or develop at the point of mobilization. In the model used here it is the point of energetic change at which sympathetic arousal takes over from parasympathetic arousal. Mobilization is therefore rather like a fulcrum – an energetic balance point.

Mobilizing depends on sufficient support for action from the environment together with self-support. There is a point of differentiation in mobilization because it has more sense of an 'I' in it. Mobilization therefore plays an important part in the process of 'selfing', moving the individual towards the contact boundary. Energetically, mobilization involves a gathering of self-support, the turning outwards of attention and a preparation to reach out. It is at the stage of mobilization that desires, needs and intentions begin to translate into expression; the possibility of aggressing – acting at the contact boundary – into the world becomes real. It is a point at which there is choice, potential and agency.

Through the lens of trauma theory, however, *im*mobilization is adaptive because of its survival value in the face of inescapable threat. We have seen that when active defences under threat are not possible the organism's instinctual response is to become immobile. This may happen in one of two ways: by freezing or by submission, both being driven by the fear circuitry of the limbic brain. Fogel (2009: 151) suggests that there is a relational and co-regulatory mechanism involved in immobilization. A predator may become more aroused by fight or flight reactions and therefore the victim modulates the escalation of the threat by becoming still or playing dead.

The Gestalt therapy belief that in all situations we are doing the best we can is perhaps nowhere more pertinent than at times of literal fear for our lives. Viewed from this perspective there need be no cause for recrimination or self-blame for the failure of active defences, though as we shall see it is often extremely challenging for clients to accept this. Immobilization can have a radical impact on the victim's view of themself in the world, and on their self-esteem. Trauma clients are almost by definition highly attuned to the wider field, and may lose their sense of capacity to act autonomously in situations which resemble trauma. The victim often experiences severe conflict arising from the wish to act and the

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impossibility of doing so. From a cognitive perspective, a limbically driven immobilized defence is not a function of conscious voluntary control. There may be changes in energetic capacity resulting in different degrees of immobilization. However, a perspective on the defensive function of immobilization is invaluable to the understanding of the therapist, and for the client in developing compassion for the self.

When immobility becomes chronic it can be seen as part of unhealthy process because it does not relate to the actual situation – no matter how real it may feel at the time. It becomes a fixed gestalt through which the victim repeats and relives the original trauma. Immobilization is rarely total in the life of a trauma victim, but may rather involve changes in the energetic capacity to maintain the figure formation, and the degree of immobilization will likely vary under different conditions. Until the stage in therapy has been reached at which a client can restore mobilized responses, we have no alternative but to consider immobilization as a healthy and creative adjustment. Immobilization resulting from trauma needs to be distinguished from resistance, stuckness and impasse, though these may also exist as part of the whole clinical gestalt.

Two kinds of helplessness in the body

One way in which immobilization manifests in trauma clients that sets it apart from 'neurotic' resistance, stuckness or impasse is that it is not only a psychological construct but is also physiologically and structurally embodied. *In addition* to the physiological responses to threat involving the autonomic nervous system and neuro-chemicals, the muscular and skeletal systems of the body are major players in immobilized responses. Kepner defines what he calls 'adaptive body structure' which 'profoundly affects our physical being in the world' ([1987] 1999: 48). These structures are characterized as being:

1. consistently and persistently used over time
2. either frozen into the musculature so that the structure is continually visible, or preprogrammed muscular responses that channel energy and movement into a stylized movement pattern
3. automatic and involuntary (under most circumstances)
4. not easily or comfortably modified merely by trying to stand or move differently (i.e., behavioural change)

Such structures develop as subjective phenomena in the context of the total field, and have meaning. Kepner describes the inhibition of

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movement as a disowning of body self, the removal of 'I' from embodied experience (p. 51). Other writers concur with the view of body structures holding memory. Boadella (1987: 7) considers that tensions of the body can be understood as 'a person's frozen history'. Similarly, Fogel (2009: 40) states: 'the memory of the situation becomes frozen in the flesh that has tightened in reaction to it' and that this can happen on a cellular level.

Experiment

Drawing 'analogs'

This experiment is a way of making visible our inner experience. It is included here to help you get a vivid sense of two very different feeling states associated with immobility. Please read through the instructions before you begin. There is no right or wrong, good or bad way to do this; whatever you produce will be right for you. Take a sheet of plain A4 paper and divide it into two. Using a pencil, mark one section 'Freeze' and the other 'Collapse'.

In each section, one at a time, make a drawing using one or more marks or lines in whatever way comes to you of whatever the word in that section stands for. The one restriction to this is not to use any words, symbols or pictures in your drawing. Use only line – hard, broken, smooth, flowing – to express the word. Try not to have any idea beforehand of what the drawing will look like; it is best to sense your way into the word from inside yourself and then allow it flow down your arm, into your hand and onto the paper. Allow five minutes for each of your drawings.

When your drawings are finished, you may like to add some 'tag' words to them. Taking another piece of paper, write about your drawings, the images that for you represent each of these two words, paying close attention to the differences between the two experiences as well as to how you drew them.

(Adapted from Edwards [1986] 1995: 66–8)

Keleman's thinking about forms of somatic distress (1985: 103ff) includes helpful descriptions of the rigid body and the collapsed body, which correspond roughly to the two patterns of helplessness deriving from trauma. Both structures may be observed in one individual, changing according to fluctuating levels of arousal. He describes rigidity as arising from loss of basic emotional support, which is a condition that many trauma victims experience, including the possibility that their fear may cause others to

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withdraw (p. 104). This loss of support from the environment results in the individual becoming overly reliant on themselves and the skeletal bracing which holds and separates. The general stance of the rigid structure is stiffened and braced, pulled upwards and backwards. There is a compression within the skeletal muscles and bones and resistance to the gravitational field. Muscle tone increases in 'strength, thickness and endurance' and there is little sense of inner support (p. 108). Clinical practice shows that there is much effort involved in sustaining this kind of rigidity. To put this into context, one client told me that freezing was helpful because it allowed her to separate mind and body.

In Keleman's view, the collapsed structure by contrast is seen as an adaptation to lack of emotional nourishment and may convey a need to be rescued. Keleman describes low levels of excitement in the collapsed form, with pools of excitement 'gathered . . . deep inside in a private place' (p. 136). The collapsed person has weakened muscle function, a sagging quality unable to resist the force of gravity. The inner core of the body lacks structure and collapses in on itself, and pulsation dies down. Rather poignantly Keleman says, 'Nothing can move through the organism' (p. 141); there is a kind of stagnation in which energy, impulse and memory become pooled in the body's systems. It is the collapsed state that can keep trauma clients under the duvet for days on end, fearful of engaging with the world, and needs to be distinguished from the restful recovery of the parasympathetic state; it is a trauma-generated symptom.

It is clear that both muscle tone and energy are implicated in the structure of these somatic forms. Body therapists divide muscle tone into hyper-tonic and hypo-tonic and these can be tracked by observant therapists. The ability to respond is facilitated by the maximum adaptability of muscle tonus, providing control over a maximum of possible responses (Bartenieff, interviewed in Johnson 1995: 277). In either state of immobilized defence there is a pattern of muscular contraction and release – a motoric gestalt – that is interrupted by extreme threat. In the frozen state there is heightened contraction, and in the collapsed state there is insufficient containment.

Laura Perls calls this kind of paralysis a 'half-orientation' with a 'dim . . . awareness of the responsibility of motoric activity for whatever changes in the situation' (1992: 126). It is important to understand that contraction of a muscle or group of muscles is really only half a movement; an incomplete action. Any fully expressed movement requires both contraction and expansion of muscle. Consider the action of preparing to throw a ball: the arm and shoulder draw back, gathering or mobilizing energy before releasing into the forward thrust. Muscular contraction and release occurs naturally also in breathing, frozenness being associated with inhalation and collapse with exhalation. Breath is one of the bodily

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functions over which we have a degree of voluntary control, which has implications for therapy with immobilized trauma clients.

It is but a small step now to link muscle tonus to states of arousal. In hyper-tonicity more energy is held in the system than is required for optimal functioning, while in hypo-tonicity it seems that excessive energy is required in order to complete actions. Reich ([1945] 1990: 340) proposes that blockage of energy goes with increased tonus and we can conclude conversely that draining of energy goes with decreased tonus. It is possible to 'map' the theory of muscle tonus onto the cycle of experience whereby hyper-tonicity relates to sympathetic arousal and mobilization, and hypo-tonicity relates to parasympathetic arousal and immobility. Likewise, in the Window of Tolerance Model hyper-tonicity corresponds to hyperarousal and hypo-tonicity to hypoarousal. Muscle tension can be a way of suppressing unpleasant feelings (Fogel 2009: 197), and changes in muscle tension are related to changes in emotional state (Fogel 2009: 192). Freezing is not just a lack of movement but 'an integrated, functional behavioural pattern' (Fanselow and Lester cited in Ogden et al. 2006: 94).

The psychological impact of helplessness

To experience a state of helpless immobility, whether frozen or collapsed, is in itself terrifying and traumatic. This may be because it has similarities with death, which it is only human to fear (Levine 2010: 16). We may understand this in terms of an adjunctive psychological death of aliveness and of an embodied sense of self. Fear generates the helpless condition in the first place; fear hinders trauma victims from fully experiencing the helplessness that otherwise moves towards completion; and fear then prevents an exit from the helpless state. Thus a self-perpetuating feedback loop is established, in which the linkage between fear, immobility and trauma paints a 'complex and nuanced portrait' (Levine 2010: 62). Retraumatization is difficult to avoid in such conditions, wherein victims may experience depression and loss of pleasurable contact. Having said this, it is important to point out that helplessness is not the same as 'giving up', resignation being more conscious and voluntary.

Our ways of being in the world – the processes that support or hinder the interface between self and environment – are of fundamental interest to Gestalt therapists. Devastating events radically alter our ways of being in the world cognitively, emotionally, somatically and relationally: 'Confrontations with violence challenge one's most basic assumptions about the self as invulnerable and intrinsically worthy, and about the world as orderly and just. After abuse [or trauma] *the victim's view of self*

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and world can never be the same again' (Reiker and Carmen cited in van der Kolk and McFarlane [1996] 2007: 15, my italics).

It is hard to overestimate the scale of damage to a victim's self-concept that can be wrought by trauma. Clients who have experienced a lifetime of trauma may never have had a lived experience of safety and therefore may not experience the loss. There is a myriad of possible manifestations of specific difficulties in relation to self-concept, in multiple combinations. Some broad themes, however, stand out.

The fact that a trauma victim has been unable to complete an active defensive movement and has of necessity resorted to an immobilized defence may lead them to feel betrayed by their own body. They do not have a way of understanding the necessity of their adjustment. Add to this the numbing effect of opiates released in situations of extreme danger described in Chapter 6, inherent difficulties in modulating arousal, and the loss of balanced postural support, trauma clients may come to profoundly shut off from any sense of relationship to an embodied life. It is as if they become existentially disembodied. The body may be viewed as something that simply supports a cognitive life by providing nutrients, air, locomotion and so on. This may mirror the objectifying of the body that often features in interpersonal trauma.

Such disconnection from bodily life can feel embedded and unyielding, particularly as a consequence of chronic muscular inability to contain an adequate amount of charge to allow an energetic flow through the body. The ability to feel sensation and impulse may barely register in the lives of trauma clients and they therefore have difficulty organizing a clear figure around awareness of needs. In the absence of a clear sense of body it becomes more difficult to orient appropriately to the demands of the world and to a sense of the present. More positively, however, these clients may function well in education and the workplace where intellectual ability is important, so long as stress can be managed. On the other hand, many underachieve.

Levine links the bound energy of frozen or collapsed states with the high emotional charge of terror, rage and helplessness (1997: 100). For him, helplessness is an emotion. He suggests that it is this linkage with overwhelming emotion that makes it difficult for humans to move out of an immobilized state (Levine 1997: 101). However, more than simply an emotion, helplessness includes a state of profound tonic immobility.

Core beliefs of trauma clients centre around weakness, cowardice and being out of control: 'The helplessness [. . .] that follows inescapable shock is due to lack of control rather than to the shock itself' (van der Kolk and Greenberg 1987: 67). Victims may scorn what they perceive as weakness in themselves and others. This may present as a lack of understanding of personal needs, a belief that it is 'selfish' to privilege one's own

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interests over another's, or the complete inability to make a decision. For trauma victims there can be strength in self-denial. Therefore these clients often talk of feeling trapped, unable to know which way to turn or to deal with difficulties. They may be unable to conceive of a better life and become hopeless, with a foreshortened sense of the future. Sadly this points to a loss of imagination, the energetic spark that enlivens a sense of purpose, creativity and self-directedness. Gestalt therapy places value on the capacity for self-determination and authentic action, which enables lively and robust engagement with the current field. Done well, Gestalt therapy can do much to restore the victim's sense of being in control.

Interestingly, helplessness may be another generalized conditioned response to trauma, and therefore affects multiple areas of the victim's life. Flannery suggests that learned helplessness is a 'condition in which patients lose their capacity to appreciate the connection between their actions and their ability to influence the course of their lives' (1987: 218). Conversely, some clients may assume an all-powerful position which, having an unstable ground, is fragile and brittle. In such a case there is a disowning of the vulnerability that is part and parcel of helplessness. Trauma clients can get stuck in the roles of victim, rescuer and persecutor which arise from their helplessness.

The shame of helplessness

It takes a tremendous amount of courage, determination and endurance to live with the lasting effects of helplessness. There is also much to grieve for as survivors connect with what they didn't have. This process often leads to a sense of existential despair that takes much resourcefulness to face. Trauma clients may blame themselves for not having protected themselves actively. While the subject of shame is the focus of Chapter 9, it is relevant to the discussion here too. Flannery considers that people who hold themselves responsible for a situation are more likely to report feeling helpless (1987: 220).

However, blaming oneself in the face of environmental threat may also serve to mitigate the feeling of severe helplessness (Ogden et al. 2006: 263), by creating an illusion of having been in control. According to Herman (1992), the inability to act with autonomy sets up conflicts that lead to shame and doubt. She states that 'shame is a response to helplessness, the violation of bodily integrity and the indignity suffered in the eyes of another person' (p. 53). It is easy to understand how this leads to confusion about self-as-agent and further withdrawal from the field. Previous experiences of mastery are cancelled out in the self-concept of these clients, with a deep sense of loss of the 'self I once was' or of potential. In

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the 1976 film *Sybil* the lead character remarks that through her mother's sadistic abuse all hope had died.

A last aspect to be considered here is that trauma clients tend to identify strongly with their trauma. This may be as a consequence of their loss of a sense of their previous selfhood, but equally it will be because of their excessive focus on the trauma. The all-consuming experience of hypervigilance, ruminations, avoidance and warding off intrusive thoughts, images, nightmares and flashbacks tends to define the victim's self-concept. 'I am not in control' is a recurring theme in the lives of these clients. Perls et al. describe two processes of the self/other field at the contact boundary: identification and alienation ([1951] 1998). There is a reciprocal shaping of self and other according to what aspects are identified with and alienated from. In a healthy contact process, these aspects are dynamic, choiceful, flexible and engaged. The contact boundary is a point of differentiation. From a trauma perspective, however, the client identifies with those aspects of the field that relate to traumatic events and their associated survival functions. To the extent that victims perceive the field as traumatic and identify with it, they alienate from aspects of self.

In trauma there is a radical denial of personal power. It is relinquished to those aspects of the field that are identified with and perceived as holding the power to determine the course of one's life. In the actual traumatic moment, 'almost by definition, the individual's point of view counts for nothing' (Herman 1992: 53). The same can be said for their impulses and desires over time as the unresolved and immobilized defences become embedded. The victim's life is often at the mercy of others, the situation becoming fixed and incorporated into their belief system. The locus of control in life therefore gives way to the perceived other; in Gestalt terms this is a shift in the boundary of responsibility. People and situations that have been hurtful continue to be a forceful presence in victims' lives long after they have moved on or ceased to exist. The field is not only dangerous, it is powerful.

Locus of control shift

Immobilization results from an imbalance of power between self and other/environment. The locus of control in the victim's life is shifted away from the self (Rotter 1954), with concomitant consequences for their sense of self as agent. When trauma victims perceive the locus of control as outside themselves they feel as though their subjective experience, their symptoms and their suffering are not of their own making, and therefore that they can do little to change the situation. Sometimes clients' extreme passivity creates a relational position in which they are simply waiting for

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the next wave of events to overtake them, lurching them from one crisis to another. It is sometimes the case that clients only feel safe in a submissive state, echoing the defensive function of helplessness, which, for example, is protective in ongoing abusive relationships.

Unreflective attachment patterns are often problematic, and the shift in power serves to prevent self-destabilization (Bromberg 2006: 7). By displacing attention from self onto the other, the integrity of the self is less under threat. Philippson considers that a fear of loss of control always implies a split between self-states, one part remaining 'in control' while the other is massively dysregulated (2001: 66). Clemmens describes how passive clients come into therapy in order to be 'treated' ([1997] 2005: 32), current conditions in a medicalized mental health system reinforcing this position. While we emphasize the need to restore autonomy, from a Gestalt perspective this must not be at the expense of the interpersonal (Wheeler 1998: 99). Instead, we assume that increased relational skill brings with it some personal power.

Furthermore, not being believed, loved, listened to or taken seriously reduces a sense of personal power, and this is also part of the field paradigm. Clients with complex trauma cannot have a clear sense of self when self-regulation has not been supported relationally. This also has an impact on their ability to be empathic, dialogic and to mentalize. When the outer field has betrayed them, they cannot even turn to themselves reliably. The actions of the abuser may come to feel like a betrayal by the body, and herein lies a confusion about self and other boundaries. Rather than relinquishing control to the other, some clients respond to helplessness by becoming overly controlling in different contexts, and may feel as though their autonomy is threatened by therapists' interventions (Loewenstein and Goodwin 1999: 80). In such ways, the locus of control becomes dichotomized and rigidified; a balance of power within the whole relational field is the preferred position. Trauma theory requires a perspective that also includes *actual loss of control* at the moment of trauma and neurological function in its aftermath.

Agency, choice and autonomy

To have a sense of personal power supports the making of choices which in Gestalt therapy is viewed as an indicator of healthy process: fluidity, 'response-ability' and autonomy. A goal of effective Gestalt trauma therapy can therefore be defined as expansion of the field of choice: 'To be empowered means to be able to choose between options, move towards the chosen object with grace and accept the consequences of one's actions' (Melnick and Nevis 1986: 43).

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Agency can be understood thus:

> The ability to act on the environment or on oneself in new ways (by altering one's behaviour) with intention towards a goal is what we call *agency* or *being an agent* in one's own life. Agency is a . . . phenomenon comprising both this capacity for deliberate action as well as the *sense* of agency, or the *feeling* that one is able to act as an autonomous agent.
>
> (Grigsby and Osuch 2007: 38, original italics)

An act of agency is a way in which the organism can alter its own state, and is dependent on the physiology of the organism. Helplessness represents a loss of capacity to self-regulate because agency includes regulatory acts concerned with getting needs met. Some trauma clients learnt early in their lives that emotions, arousal and action are dangerous self-experiences which could not be used to develop a sense of agency or to initiate in relationship with others (Sapriel 2012: 107–8). To be in action is to be oneself (Naranjo 1993: 202). There is a fundamental loss of self in helplessness in the context of agency as an invariant of self (Stern 1985: 71–6). Deferring to the field comes as a later response to environmental factors.

Lynne Jacobs (2006: 14) states that 'The experience of autonomy and agency is not a product of independence, but is an emergent phenomenon that is utterly dependent on smoothly functioning interdependency'. Thus she places the development of the capacity to choose within the context of the relational field. Another function of agency is to 'notice or empathise with the other and perception of the other as an independent agent' (Fogel 2009: 223). With no sense of agency, one is not living one's own life. When one loses a sense of control one loses also a sense of volitional self-direction (Piers 2007: 101). In addition to the relational considerations of helplessness, agency is a function of the body. There is no freedom of choice in a clenched muscle, nor in one that cannot hold sufficient energetic charge to support action. Chronic repetition of stresses reduces conscious voluntary control of the musculature at the centre of gravity (interview with Hanna, in Johnson 1995: 349) and in the limbs.

Taking action

Herman was probably the first of many trauma therapists to make the link between the experience of safety and the body: 'Establishing safety begins by focusing on control of the body' (1992: 160). Similarly, Fonagy et al. state: 'Of course, the core of self-agency must lie in the body' (2004: 58).

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Control of the body implies volition, directionality and energetic flow. The question therefore for therapists working with clients who are frozen or collapsed is one of how to support the re-emergence of these functions and reverse the defensive sequence. The Gestalt psychotherapy approach to calibrated experimentation fits very well here, which can also introduce the possibility of curiosity about self-in-process and playfulness. Both have been missing from many trauma clients' lives.

Fortunately, there are some somatic resources available to anyone over which there is a degree of voluntary control. These include the breath and skeletal muscles. We can use either of these as starting points in thinking about how to work with immobilized and helpless clients. Breathing has a regulatory function, as seen in Chapter 4. Mobilizing requires the gathering of sufficient breath for the task in hand. When working with breathing, clients sometimes assume that they are trying to attain an 'ideal' breath (interview with Speads, in Johnson 1995: 42.), but this is not the case. We need different kinds of breath for digging the garden, brushing our teeth, watching television, or to deal with an attacker, for example.

This highlights one caveat for working with breath with some trauma clients. Where breath may have been significantly impacted at the time of trauma, perhaps by hyperventilation or in being or feeling smothered, this is an access route to voluntary control that must be avoided at first. With enough trust in the process, therapists can be assured that when a client becomes more regulated by whatever means, the breathing will follow automatically. Given the right conditions, the body knows how to regulate. There are many commercially available resources to guide therapists and clients who are interested in the benefits of conscious breath work, and countless ways to encourage awareness of breathing within the therapy setting. Usually these are meditative experiments in directed awareness (see Chapter 5), sometimes by quite briefly attending to a few breaths, and at other times more prolonged staying with attention to breath.

With practice over time, clients can learn to 'bring breath', as it were, to different parts of the body. This can either support the notion of breath filling the cavities of the body giving rise to an enhanced sense of the body as a container or of the whole body, or another alternative is 'directing' breath to particular areas, perhaps of ease or pain. The therapist can also use their own embodied presence including breathing to help regulate the client. Attention to breath is exquisitely experience-near and gives rise to a sense of 'self-as-breather'. It can bring about a sense of expansion and flow in the body and a release of muscular contraction. 'We must recognize and sense the connection between breathing and bodily movement and bring about their correlation' (interview with Gindler in Johnson 1995: 10).

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Experiment

Lie down on the floor or on a mattress, stretching out your arms and legs. Allow the backs of your hands to touch the surface you are lying on, and perhaps also your elbows and upper arms. Now raise your right upper arm by a shoulder movement only, until the back of your hand just ceases touching the floor, making, in fact, a slow, infinitely small movement. Then let your arm drop back down to the floor and rest there. Raise your arm again until the back of your hand leaves the floor. Repeat this twenty or more times, each time you raise or lower your arm making a complete pause. Stop all movement and let the next movement be an entirely new and separate action. If you pay close attention you will feel that the back of your hand is beginning to creep along the floor a little as it stretches before it is raised. You will notice as you repeat this that lowering your arm coincides accurately with the moment at which air begins to be expelled from your lungs. Allowing yourself to rest, observe the difference you can now feel between the right and left sides of your body.

(Adapted from Feldenkrais [1972] 1990: 93)

Movement involving skeletal muscles (as opposed to the movement of internal muscles such as those involved with peristalsis over which we have no voluntary control) has different dimensions concerning time, space and relationship; it is always in and of the field, both contemporary and historical, towards or away from something other; in, out, up or down. Our habitual movements are reactive and patterned by procedural memory, usually being evoked by stimuli outside conscious awareness (Ogden et al. 2006: 130). We may recognize that we are thirsty but perform the complex sequence of movements involved in making a cup of tea without a thought for how our limbs and body are executing them. It can be revealing to do something like this slowly and mindfully. Movement has an immediacy which makes awareness of sensation more accessible (Ogden et al. 2006: 220) and can therefore be regulating. Awareness is one means of bringing movements under greater conscious control, enabling vivid sensory experience, by encouraging clients to feel into them and notice sensations. Trauma clients need to recognize impulses as signals requiring attention and having meaning and value, rather than reacting automatically to them.

Another way is to provide experiments in deliberate and conscious movement. New clients who are unused to working with the body might first be invited to imagine making a movement or feeling a sense of control

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in their body. When you simply think of making a movement you change the tonus and circulation of the body (interview with Alexander in Johnson 1995: 259). This alone can begin to reorganize somatic experience and a more responsive embodied sense of self.

Trauma clients, even when quite frozen and still, tend to have a recognizable movement vocabulary. Key features are that these movements appear to be without purpose, neither expressive nor directional, and seemingly incongruent and disorganized. Broad vague sweeping movements of the arms, the lifting of a finger, a twitch in the foot, jerky and abrupt walking are all examples of movement which is disorganized, involuntary and unaware. Each can be understood as having potential meaning – Parlett's Principle of Possible Relevance (1991) – particularly in respect to incomplete defensive actions. Attention can be directed to these small indications of rising energy, noticing the gathering of the impulse, and this can encourage a fuller expression or directionality.

A Sensorimotor Psychotherapy technique is to organize movement by offering resistance, for example by pushing into a cushion held by the therapist (Ogden et al. 2006: 250) or by lying on the floor and pushing away with the legs. The right level of resistance offered at the right time can thereby alter the client's sense of differentiation and power in the body and they can find this a highly rewarding experience. It is surprising that sometimes quite small movements can make a huge difference. One client was stuck in a paralysed state, unable to move her arms or upper body, and terrified. She discovered that she was able to move her left leg upwards and from this the rest of her body released, and she said this helped her feel more powerful. Such experiments, as with all body-based trauma work, need to be done with as much mindful awareness as possible of the full range of muscles involved. Therapists can learn to observe changes in muscle tonus that signal escalating arousal or a client withdrawing their presence. To do this it is necessary first to become familiar with the individual client's 'base level' of tonus when not dysregulated.

The smallest movements a frozen or collapsed client can manage may be those involving the eyes, looking around to check for signs of safety or for objects to ground experience in the present moment (Ogden et al. 2006: 217; Boon et al. 2011: 5). It is surprising how transformative such minimal actions can be, orienting the client to the safety of the present. Movements involving the trunk or the limbs may also be quite small but nevertheless have a considerable impact in reorienting the client and mobilizing their energetic shift towards a more regulated and adaptive state.

Further examples, also from Sensorimotor Psychotherapy, include pressing the feet into the floor, or lengthening the spine a little. The therapist may model this somatic awareness by carrying out the experiment alongside the client and reporting on the sensations involved: 'I can feel

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this between my shoulder blades, how I use my tummy muscles, that the push/pull comes from my pelvis – do you get that too?' Of course the client may not yet be able to do so, but the experience is there all the same and the potential for feeling it is enlarged.

Mindfully performed actions can introduce movement into an otherwise sluggish process, especially those based on yoga or tai chi (Emerson 2008; Nhat Hanh 2008). Severely frozen, collapsed or hypoaroused clients may actually do better if they are invited to stand up and move around the room, with suggestions to 'Walk towards the window, now walk towards the door, now change direction, now change speed', increasing orientation, purpose and a sense of control as well as bringing energy to the system (Ogden et al. 2006: 130). In each case these experiments can be adapted to suit the immediate needs of the particular client. For those most profoundly collapsed clients, it requires tremendous strenuous mental and physical effort to move out of their helplessness, effort '*which is by definition mostly absent in this condition*' (Nijenhuis et al. 2006: 329, my italics). Therefore these movements and actions may need to be repeated many times in order to become established and integrated. Bartenieff, quoted in Johnson (1995: 236) observes that when you repeat a movement the next time you go a bit further.

All of the ways of working described above challenge the client's traumatically generated, procedural and implicit ways of being in the world; their potential autonomy increases as does their sense of themself. Kepner (2002) associates a sense of personal capacity and strength deriving from muscular and movement capacity with the sense of being able to cope. Feelings of mastery and of competence can develop from this work: the sense of 'I can' which has not been available before. This in turn provides a basis for increased resilience in the face of demands and challenges in everyday life. Mobilizing requires the ability to aggress into the world in the Gestalt sense, meaning to move forward freely in order to make good contact and satisfy needs and impulses.

There is a link here to anger, which can literally be the backbone of recovery from trauma. Of course, for many trauma clients anger evokes either terrifying memories or an intolerable intensity of emotion, or both. Anger needs to be handled in a sensitive and nuanced way. However, it is pertinent to the subject of helplessness, to the locus of control shift, and to the radical alteration of self and field organization. In terms of Oaklander's statement that 'anger actually is the essence of taking care of oneself, getting one's needs met, making one's statement, establishing one's position in the world' (2000: 267), anger is an entirely appropriate and necessary response to the incapacitating experience of trauma, and its emergence in therapy can indicate a turn towards greater mobilization and response-ability. However, anger is often experienced as

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unpleasant or triggering and may be avoided as another anticipated experience of pain.

Gestalt therapy, in its interest in the co-creation of contact, refuses to acknowledge total helplessness. Defensive responses whether mobilized or not may not be a matter of aware choice, but they do belong at least with the victim. The recognition of one's part in something – the Gestalt value of ownership and responsibility – including the survival function of immobilized defences, gives some power (Delisle 2011: 119).

Case Study Part 2

Eve's understanding of hypoarousal soon became clear to me, when she went into a tired, dizzy and floppy state, telling me she needed to lie down. The first few times this happened in sessions I felt pleased that she could tell me what was happening and ask for what she wanted. I thought this was a parasympathetic response and duly provided blankets and cushions so that she could 'recover'. I needed to change gear quite rapidly when I learnt that this didn't have the desired effect, Eve having gone from a potentially balancing parasympathetic state into collapse too fast, without any control over this process. Eve took a very long time to recover from these episodes, which became more frequent.

In relational terms, she agreed that she now felt safe enough to let me know how her body was remembering the terror and inescapability of the rape. Increasingly able to observe and put words to her experience, Eve told me that she felt enormous heaviness in her chest at the start of these episodes, as though she had woken during an operation unable to move because of the drugs she had been given. The challenge of gathering her energy and taking action was considerable. For a long time we had no way of helping Eve find her way out of this state, other than by slowly introducing deliberate movement, especially in her legs.

As she entered a collapse, I noticed that Eve would move her left leg outwards, and although I didn't know the meaning of it I imagined it was based on a memory of a truncated defensive action. There was little energy in this small movement, but I wanted to capture it and see what potential there was in it. The sensations associated with rising energy triggered Eve because she feared losing control, until she learnt ways of managing and containing the charge in her body. Setting up experiments in which she could begin to turn this movement into a small push felt strong and powerful to Eve and we paid close attention to her integration of this somatic resource.

The downside for Eve of finding this movement was that she contacted her anger, an emotion that held a sense of danger for her. She recalled

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trying to talk to her father about her grandfather's behaviour, and his dismissal of her feelings. More than her grandfather's behaviour, Eve was angry with her parents' reactions. We did a great deal of painstaking work unpacking her feelings about anger and herself as an angry person, needing to calibrate carefully and slowly what she could tolerate. Because Eve imagined anger as being out of control, she made sense of her helplessness as a way of retaining some degree of control. Any feelings of anger towards her attackers were right outside of her awareness for a long time. Interestingly, it was an expression of frustration on my part towards Eve that opened up the space for her to grow into her own anger. She began by quietly telling me that she was upset with what I had said, and later found the capacity to stand up for herself more with her father.

To begin with Eve was triggered by attention to her breath, because it reminded her of how her breathing was affected during her rape. Over time she became more confident in working with breath because she could observe for herself how it settled her and deepened whenever she entered a more resourced and present state. Now she became more choiceful, beginning to use her breath consciously to manage dysregulated states, in and out of sessions. Using techniques and resources for herself she said helped her regain the power that had been taken away from her, and slowly dissolved the helplessness she had developed.

Eve told me: 'I feel buffeted, badgered by the situation at work, it takes me to a dark place, where I need to defend myself and get it right for other people and I don't know how to do that, I don't know what's right for him any more. But it's not about them, it's about me. When I push with my legs I feel anger, and it's scary and it's good too. Anger, it's energy isn't it? It's unjust when my boss shows me up like that, and when I say those words I feel more alive.'

Summary

The ability to make choices based on well-formed figures of contact is valued in Gestalt thinking. This supports a sense of existential freedom, response-ability and differentiation in self-functions at the boundary between self and other. The role of mobilization is key to the formation of such figures, which arise from sensation and awareness. Mobilization is the point on the cycle of experience at which energy is gathered and parasympathetic arousal turns to sympathetic. Under conditions of extreme threat, however, active mobilized defences may come to be aborted where survival is more likely by entering a submissive helpless state. Immobility is therefore a creative adjustment which is physiologically structured and it can become

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generalized to many situations in a victim's life. Furthermore, helplessness can be understood as definitional of trauma, because its link with terror produces trauma reactions.

An embodied sense of self can be profoundly affected by immobilized defences. The helpless states felt by trauma victims involve frozenness and collapse. A frozen state may include agitation or paralysis, or both. Either state may be present in different forms in a single client or in a single moment, varying by degree according to current perceptions of safety or danger. Helplessness is embodied through breathing and muscle, where the energetic charge needed to support an action or movement through the cycle is not available or organized. Rigid and collapsed body structures – patterns of somatic distress – organize energy and muscle in recognizable ways and reveal much about the client's habitual ways of being in the world.

Because of the overwhelming impact of events in the field of experience, trauma clients' sense of self is greatly impaired – the world is something that they are unable to influence and they may feel less able to determine the course of their lives. Shame, weakness and cowardice may become aspects of the client's experience of self in relation to the world. These clients can have difficulty incorporating the trauma into their former self-concept. In their feeling that they can never be the same after a traumatic event, they tend to allow the trauma to define them. Thus the locus of control over their lives shifts towards the environment, and they become acutely field sensitive. It is difficult for clients to understand their immobility as the creative adjustment that it is, and they carry blame for what happened to them.

In order to restore a sense of self-as-agent it is necessary to reverse the immobilized patterns held in the body. Many experiments are possible to support the reorganization of somatic experience to include a bodily sense of power, which can be linked to restoration of safety. Such experiments can be built around increasing sensation and developing a sense of directed and purposeful movement. Resources can be established which recall moments of mastery in the past or imagining mastery in the future.

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8 From disconnection to contact

Dissociation is a feature of trauma reactions that is biologically and psychologically driven. This chapter explores this phenomenon, arguing that as necessary for survival, it can be seen as creative. The effects of dissociation on the body are discussed, placing them in the context of neurobiology. Further, the effects of dissociation on the self causing fragmentation are developed, and the Structural Dissociation Model is presented. The implications of fragmentation for relationship are explored, before the chapter moves on to describe some thinking about how contact can be increased for these clients. Eve's story is continued.

> Traumatic events call into question basic human relationships. They breach the attachments of family, friendship, love and community. They shatter the construction of the self that is formed and sustained in relation to others. They undermine the belief systems that give meaning to human experience. They violate the victim's faith in a natural or divine order and cast the victim into a state of existential crisis ... Traumatic events destroy the victim's fundamental assumptions about the safety of the world, the positive value of the self, and the meaningful order of creation ... Traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life.
>
> (Herman 1992: 51–2)

In the aftermath of trauma the ground on which one's existence rests is shattered. Such devastating disconnection is bound to raise questions about the self in relation to the world. This profound existential crisis is deepened by a sense of alienation from the vital, experiencing self. Traumatic experiences often lead to dissociation, which is particularly challenging for clients and therapists alike. Trauma-based dissociation is

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a kind of living death, in which daily life can feel like little more than 'going through the motions'. People who suffer from dissociative experiences following trauma can feel as though they barely exist in any meaningful authentic way, and often describe themselves as being in a fog for much of the time.

Theoretical perspectives on dissociation

The capacity to dissociate is normal and something we all do at times. Take for example daydreaming, getting lost in a book or film, 'highway hypnosis' when driving and 'missing' a chunk of the journey, or other ways of coping with boredom or overstimulation. Dissociation has other important functions in day-to-day life, such as helping us deal with tiredness and pain. Dissociation 'organizes the mind's responsiveness to novelty' (Bromberg 2006: 4) whereby we adapt our self-state to the demands of the present moment. These normal dissociative responses are fluid and adaptive. Dissociation resulting from trauma is quite different in that it becomes a more hardened and structural aspect of the personality. It helps to define dissociation by means of what it is not: it is an *absence* of association, integration, assimilation, coherence and engagement. It is important to remember that degrees of dissociation vary depending on circumstance; dissociation is field sensitive, and may range from mild and temporary to severe and chronic – the dissociative 'disorders'.

Just as the concept of the window of tolerance is concerned with contact boundaries, so is dissociation. The ability to make contact is clearly compromised by dissociation which is by definition a state outside of the window of tolerance. The relevance or existence of mechanisms that take us outside the window of tolerance, **modification to contact** in classic Gestalt terminology, are the subject of a lively ongoing debate (see Wheeler 1998; Jacobs 2011). Some of the debate is centred around the interpretive position taken in respect to the moderations to contact, which are processes that cannot easily be phenomenologically described or recognized, and interfere with authentic relating.

However, one experience-near modification to contact is **desensitization**, which relates to embodiment. Desensitization is a tuning out of attention to certain physical stimuli, though the process by which this is achieved is vaguely described. Desensitization can therefore be placed on a continuum with dissociation. We might for example become habituated to some discomfort such as a daily commute, a noisy, smelly or dirty environment or to a degree of cold if we can't afford much heating. Or we might defensively 'live in our heads', rush our food, overwork or pay scant heed to bodily sensations as a **contact style**. These two forms we can call

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desensitization, and we can see their function in regulating contact; neither is traumatically induced.

Trauma-related dissociation is at the other end of the continuum, and involves dealing with stimuli that are not necessarily connected with the present situation. Dissociation has clinical features that are recognizable as problematic by both client and others around them. Philippson (2001: 64) uses the term 'splitting' (into different self-states) as an interruption to contact; it seems he is referring to one feature of dissociation, which is a broader concept than he describes. Typically, dissociation involves a change in awareness, withdrawal of one or more contact functions, and a disengagement with current reality which may take different forms. Kepner describes dissociation as withdrawal of the energy of awareness, a fleeing from embodied life (2002). Clients may report for example an alteration in perception of sight or hearing or some other reduction in awareness. Equally, dissociation may involve distortions in memory, identity or consciousness.

Dissociation may accompany an orienting response towards a traumatic situation, but it has a quality of shutting down rather than high alert. Phenomenological observation indicates a slowing down of response and deadening of contact, a sense that the client has left the conversation or gone somewhere else. The therapist too may experience a sense of sleepiness that is difficult to comprehend especially when this becomes a pattern. Dissociative episodes last from a few moments to many days in the extreme. The idea of entering a long slow flashback is very helpful for understanding these longer dissociative experiences. Some trauma victims are capable of operating on several different levels at once, with partial attention to different figures.

Dissociation is thought to develop as a result of overwhelming experience that cannot be contained, processed or reflected upon. If an individual dissociates at the time of the original trauma, or experiences threat to bodily integrity, dissociation will become a greater problem in later life, and this can be predictive of PTSD (Nijenhuis 2004: 89). Bromberg suggests that dissociation is a means of preserving the continuity of the self in such circumstances (2001: 11).

In normal life, conflicts between the competing needs of self-states can be resolved by internal dialogue, a self-function that is damaged by trauma. Here, conflicts centre at their most basic level around the disjuncture between the need for a safe and predictable world in which one can continue to function, and a reality that threatens and destabilizes and which is felt as unbearably painful. These conflicts cannot be resolved in the same way because simultaneous access to different self-states is blocked (Bromberg 2006: 68), the barrier between different self-states being too 'thick'. The process of selfing isn't organic and the capacity to

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reflect on experience is limited. Bromberg calls this 'a thought without a thinker' (Bromberg 2006: 65). There is a truly terrible price to be paid for dissociation when one's embodied and sensory experience become inauthentic.

Depersonalization and derealization

There is a wide range of possible dissociative experiences or symptoms. Nijenhuis considers that there are far-reaching alterations in behaviour, affect, sensation, perception and knowledge which result from dissociation (2004: 108). Broad categories of these include depersonalization and derealization. Depersonalization is the feeling that something is happening but not to you, or that you are 'outside' of the body observing the event from a distance. For example it is common for clients to report that during childhood abuse they 'floated up to the ceiling' and watched from there. More seriously, many dissociative trauma victims have a degree of difficulty sustaining a more or less coherent sense of themselves, and may feel as though there is more than one 'self' which takes control at different times. Thus identity confusion is common.

Derealization involves feeling that events or people are unreal, or that common things are unfamiliar; derealization may include distortions in the perception of distance or time (Boon et al. 2011: 17). Blanks in the continuity of time are common, and more highly dissociated clients quite often 'lose' periods of time or have 'fuzzy' periods of partial recall which are not the same as substance-induced blackouts (Ross 1997: 138–9). Total amnesia for traumatic events in particular, and often for significant parts of childhood, indicates a dissociative process. Where there is some memory of traumatic events it may be experienced as fragmentary, sensory and discontinuous; victims report that their trauma memories have a different quality from memories of day-to-day events or other significant occasions. Other somatic experiences may include pain without medical explanation, or loss of speech or use of part of the body, sometimes called a conversion disorder. A hallmark of these dissociative symptoms is that they are involuntary (Boon et al. 2011: 14).

Making sense of dissociation

As a normal function which becomes overused in response to trauma, dissociation should not be treated as pathological but rather as a 'good working model for how the body deals with *any* trauma' (Cook 2012: 41, original italics). Dissociation is a far more common process in people

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who have histories of abuse or trauma than is often realized. Most people will recognize what it means to be 'beside themself' with some strong emotion; dissociation is an extreme form of this process of splitting and disembodying. Dissociation is a necessary, biologically driven means of coping with fundamental threats to the integrity of the individual, which allows ongoing functioning and basic attachment systems to survive 'given that from their point of view the trauma is not occurring' (Ross 1997: 65). One client explained: 'They can't hurt me now because I'm not there' – a great defence! Dissociation is the means by which trauma victims maintain a sense of personal continuity, coherence and integrity of self. 'The dissociative patient in his or her normal state may insist "I was not abused", whereas the dissociated cognitive system contains beliefs such as "I am weak, helpless and unworthy" or "I am strong and aggressive"' (van der Kolk et al. [1996] 2007c: 317). This fragmentation is an extraordinarily creative adjustment to events that cannot be contained in an integrated self-state. It involves an active disowning of the traumatic experience at major cost to the self, as though the client is saying, 'No, I'm not having anything to do with that'. Dissociation is therefore an active boundary process, and a resource.

Victims may have been subject to threats from their perpetrators in order to deny, to remain silent or to 'forget' what has happened. Sometimes threats have a psychotic quality, for example 'that didn't happen', which can lead victims to feel as though they are quite crazy for remembering. The family may cast the victim as the crazy one in order to protect the perpetrator and the family system. Craziness runs counter-culture, wherein the prevailing thrust is for rationality, and it is timely to recall that rigid structures are one pole of trauma responses. Thus is set up a vicious reinforcing cycle of denial at multiple layers within the 'laminated' field (Parlett 2005: 51), creating the ground for dissociation.

Dissociation and the body

Trauma is a field phenomenon, and reactions to it are functions of that field. Cultural splits about the body and about trauma, particularly sexual trauma and the abuse of children, are nowhere more acutely reflected than in dissociated clients. Dissociation is a natural response to trauma at personal, familial, societal and political levels. In individual cases, there may be reasons concerning deeply held collective attitudes and beliefs that reach beyond generalizations. Where there has been some sort of assault or abuse, the victim is likely to have been treated by another person as being less than human; their dignity and humanity have been subsumed to the desires and control of the other, their body treated as an object, their sensibility discounted.

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The physical body is a dwelling place, the centre and ground of our being and humanity. It carries the denial and beliefs of the collective. The human body also has the unique ability to ground awareness of self and other and to integrate experience. The loss of connection with an embodied self is therefore disastrous for anyone, who then feels dislocated, lost and unable to orient themselves in the world. The trauma victim may no longer be able to inhabit the truth of their story (Goodwin and Attias 1999a: 5). A dissociated victim may be able to tell their story in a disconnected way, but the truth of it cannot be known and integrated until it can be deeply and fully felt.

One client was describing her experience of depression in a way that felt incongruent; I could not feel it with her. When I pointed this out to her the client said, 'I guess I can't feel my depression in my body'. We could call this being a feeler without a body, which defines the incongruity well. There is no sense of an 'I' in the disconnected body. It can be as if the relational betrayal becomes located in the body. So the reclaiming of an embodied sense of traumatic events is essential to recovery. Dissociation has to do with knowing: 'knowing about one's body and knowing about one's self, one's past, and one's relations to others' (Johnson, undated lecture notes, via internet).

Experiment

Take a few moments to imagine a world in which people's bodies from the neck down are indistinct. Their physical selves are not all there, partly invisible, semi-transparent in places: a world of heads moving around on insubstantial bodies, talking and engaging within their limitations. Now spend some minutes writing about what is missing in this world, what cannot happen that you currently take for granted? What is the impact on relationships, on responsiveness, on awareness, on a sense of belonging, on perception and on judgements? How do you organize emotions, narratives and a sense of the world around you? What is this experience like? What feelings arise as you enter this experience and write about it?

Trauma victims tend to dis-identify with their bodily experience, or to condemn, deny or reject the sense of body, sometimes in conflict with self-states that need attention for pain (Goodwin and Attias 1999b: 172). However, '"out of mind" does not mean "out of body" . . . bodily symptoms allow the person to express mental distress without having to acknowledge [it]' (Bakal 1999: 52). The body holds many memories of trauma,

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including those of actual pain which can be relived intensely. Somatoform dissociation is a term that refers to a wide variety of bodily based phenomena, which may involve almost any of the bodily systems each with its own meaning and function. Other bodily disturbances, sometimes apparently bizarre, may be symbolic representations of hurts or somatic reactions caused in traumatic circumstances. Either involuntary or deliberate shutting down of emotional reactions may generate physical distress (D'Andrea et al. 2011: 383).

It is not uncommon for clients to experience physical pain during a therapy session as memories and feelings come to the surface. These people tend to be very alert to pain and sometimes misinterpret it, as they do with other sensations. Apparently contradictory, the withstanding of pain may be a last hold on personal identity (Scarry 1985: 347). An identity formed around the experience of pain is a sobering thought indeed. Pain is therefore a distortion of somatic experience and of the self. It is common for victims to self-medicate in various ways, by problem eating, substance abuse, overuse of opiate-based painkillers, or self-harm for its analgesic effects. The ambiguous relationship many trauma victims have with pain can be seen in their avoidance of medical care on the one hand and recurrent seeking of medical attention on the other (Loewenstein and Goodwin 1999: 77). This reflects the twin states of 'feeling too much' and 'feeling too little' which many trauma victims find so puzzling, and which co-exist even in the shut-down state of dissociation. The story told by the body is not necessarily what the 'self' tells (Goodwin and Attias 1999a: 3). For example, one client was keen to understand his condition but dissociated whenever some psycho-education was offered.

The neuroscience of dissociation

There are clear neurobiological processes at work in dissociation alongside psychological ones. The role of endogenous endorphins in dissociation seems to serves as an analgesic (Cozolino 2002: 74), helping victims to deal with the pain of trauma. The neural networks involved in the disconnection between thoughts, sensations, behaviours and emotions are separate (p. 24). These breaks in integrated organization of neural networks affect emotional regulation, attachment and executive functioning (p. 267). Damasio makes an interesting suggestion that there exist in the frontal cortex 'multiple master control sites' (2000: 354–5), the switching between which involves the thalamus. Dissociation inhibits the insula (part of the cortex) and the hippocampus from binding the traumatic memories into coherent packages, so trauma memories become free-floating, bound instead to sensory or motor situations which allow

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the memories to 'lurch into awareness' (Fogel 2009: 258). The primary executive role of the left hemisphere of the brain explains the neutral emotional tone dissociative clients often present; there may be a blockage between integration of right and left hemispheres (Siegel 1999: 320). We can postulate that alteration to the corpus callosum, the 'bridge' between the hemispheres, is involved. Dissociation goes hand in hand with profound hypoarousal of the ANS.

The fragmented self

Separate self-states are really shifting combinations of psychological and physiological factors, which we all have to some degree. One way of understanding the fragmented self is to consider each somatic phenomenon as an expression of a part or self-state. Equally, separate self-states may contain different fragments of story or memory. Dissociated parts are not usually seen in the dramatic switches portrayed in popular media but present as more subtle changes in energy and the quality of contact, as though the client is moving around a space and changing direction for no obvious reason. Dissociation often has a quality of something not quite making sense; not quite fitting. The discontinuity of contact is not always obvious, but may be picked up by the therapist as confusion about how 'we got from there to here'. When a client resists something resourcing or positive with an excuse or a 'yes but', you can safely assume that another self-state has switched in. Bromberg helpfully suggests that state switches are felt by the therapist rather than observed (2001: 193).

Gestalt therapists are familiar with the concepts of 'top dog' and 'underdog', which are really representations of part selves. Polster (1993) wrote extensively about 'selves' with diverse roles and qualities. Delisle implies that self-functions are part selves (2011: 17), related to id and ego function in Gestalt theory terms. To return to Philippson: 'Inherent in the concept of self as relational is the possibility that, in the interaction of a person with the environment, she can form more than one self, each one emergent from a different way of relating to the environment' (2001: 64).

Some degree of splitting in this sense is common to all of us. Philippson is not necessarily talking about dissociation here because this splitting is created in response to stress rather than life threat, though the process is similar. Philippson later describes dissociated part selves as processes, aligning his thinking with the Gestalt concept of self-as-process (Phillipson 2001: 65). Polster refers to 'essential' selves which can become fixed (1993: 42). Writing from a psychoanalytic background, but in keeping with this discussion, Bromberg states: 'If all goes relatively well in one's early life, one's own self-state shifts are normally as unobservable as the beating of

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one's heart, and self-state coherence goes on without disruption' (2006: 113). Stern suggests that self-synchrony is an essential feature of self-coherence (1998: 84), and it is this synchrony that seems to be disrupted in dissociative responses to trauma; all has not gone well. Stern also proposes that the ability to integrate sensory experience across modalities plays an important role (1998: 85), emphasizing that sense of self is not a cognitive construct but a felt experience (Stern 1998: 71); again these are self-functions that become more or less disconnected in trauma. Yontef has this to say about fragmentation of the self: 'This [idea of a core self] is not only a loss of wholeness, it reduces the person to an *it*, a structural entity. "*It*" gets cohesive or "*it*" gets fragmented. And that is a disowning of responsibility, a loss of agency' (1993: 269, original italics).

Although Yontef is talking about a reductionistic concept of self rather than an experiential process that is biologically designed to regulate, he describes the consequences well. What happens in the fragmented traumatized person is not reduced but a rather complex layering of self-states. The most salient factor in the theory of self after trauma appears to be that of self-as-function of the field. Ogden et al. are at pains to point out something perhaps obvious but nevertheless crucially important; that 'parts' are simply metaphors which help us to understand processes rather than *actual* divisions (2006: 137). Bearing in mind the maxim embraced by Gestalt that the whole is more than the sum of the parts, we turn to a model of the dissociated self, based on functions rather than on roles or characteristics, which helps make sense of the process in terms of creative adjustment rather than of pathology.

The Structural Dissociation Model

The Structural Dissociation Model (Nijenhuis et al. 2006; see Figure 8.1) takes the premise that with increasing exposure to trauma a person becomes more fragmented. In order to deal with inner conflict and continue some semblance of 'normal' life, trauma victims tend to reorganize their 'self' into different functions, one which holds the trauma and one which fulfils the tasks of everyday life, sometimes apparently functioning very well. This is called 'Primary Structural Dissociation', perhaps following a single trauma like a road traffic accident and often responsive to CBT and EMDR approaches. If the trauma is ongoing or repeated, the *traumatized* part may split further in ways that relate to truncated defensive functions, called 'Secondary Structural Dissociation', while the ongoing functional self continues as before. Secondary Structural Dissociation will be the main focus of this discussion. This level of dissociation really defines complex trauma, and is likely to be present in

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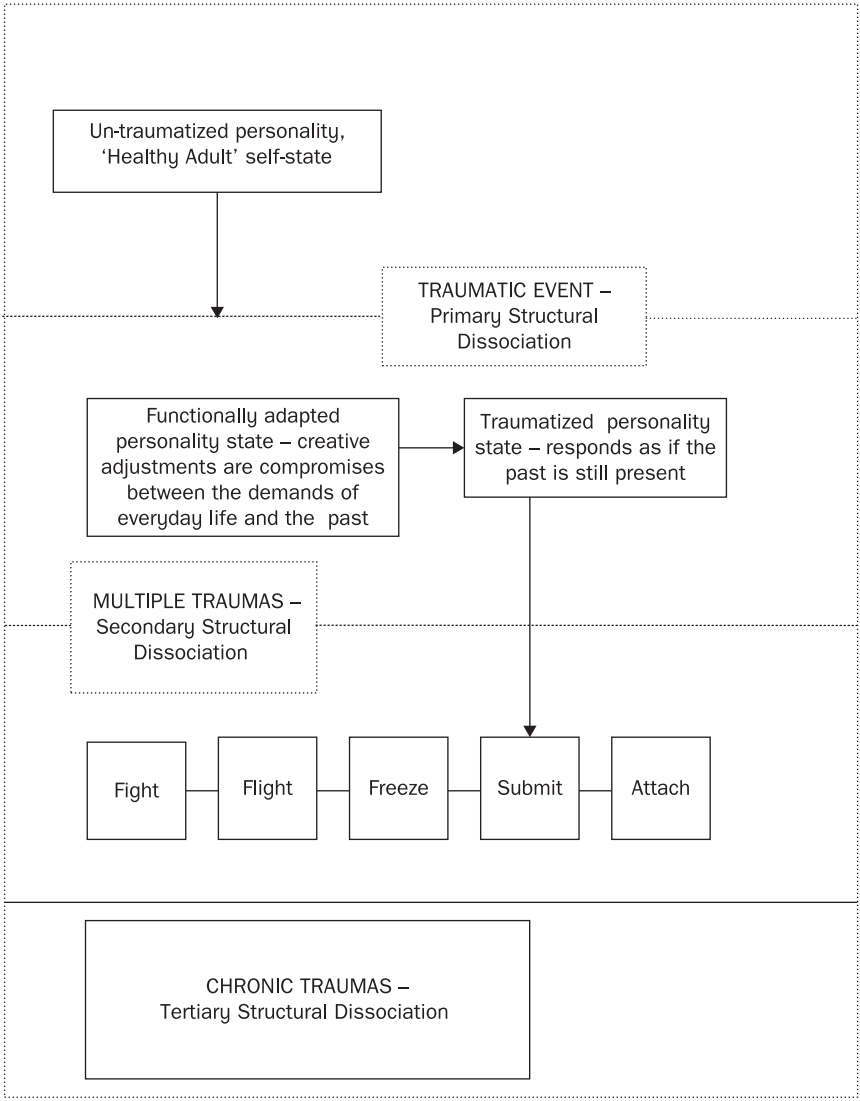
Un-traumatized personality, 'Healthy Adult' self-state
TRAUMATIC EVENT – Primary Structural Dissociation
Functionally adapted personality state – creative adjustments are compromises between the demands of everyday life and the past
Traumatized personality state – responds as if the past is still present
MULTIPLE TRAUMAS – Secondary Structural Dissociation
Fight
Flight
Freeze
Submit
Attach
CHRONIC TRAUMAS – Tertiary Structural Dissociation

Figure 8.1 The Structural Dissociation Model

(*Source*: Adapted from van der Hart, O., Nijenhuis, E. and Steele, K. (2006) *The Haunted Self*. Norton, New York)

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most traumatized clients in regular clinical practice. A further level of fragmentation, 'Tertiary Structural Dissociation', relates more closely to the dissociative disorders and specialist therapy.

In Chapter 6 the three mobilized and two immobilized survival defences were described. These are initiated by the limbic system under threat: fight, flight, freeze, submit and attach. Trauma victims have unfinished business with each of these five survival functions, which because they are not completed become fixed as structural but dis-synchronous aspects of the personality. The client is, out of awareness, perpetually concerned with a search to engage with and to complete any one – or all – of these defences in order to alleviate their suffering, however fleeting that might be. What seems to happen is that one of these self-functions might take over 'executive control' at any time, including the part that gets on with daily life. When triggered beyond their window of tolerance, the client is effectively hijacked by a distressed part, caught in the unending cycle of repetition and re-enactment.

It would be a mistake to think that these parts are as discrete as the model implies; the matter is not quite that simple. Sometimes parts come disguised as positive traits, such as a submit part having an easy-going approach to life when field conditions support this, while at other times their messages about survival functions may be difficult to comprehend. A suicidal part may believe that they are taking a protective stance, for example. The model implies that all the defensive functions are represented in the internal system, even where a client may disown their fight part or need for attachment, for example.

This is not to suggest, however, that all parts are aware of one another; 'co-consciousness' is the technical term for awareness between self-states. As with amnesia, some parts or functions may be effectively be hidden behind a dissociative barrier, as though they were shut in another room. In some states many clients are able to acknowledge some of their other self-states, while in others they are not. There can be an 'insularity and concreteness of each self-state as a black-white-island of "truth" about who one is at a given moment' (Bromberg 2006: 65), and this keeps changing. Trauma clients can feel murderous towards or frightened or rejecting of one or more of their parts. Examples of these can be seen in a client who wanted to get rid of a sulky adolescent part that was preventing her from moving on with her life and in a client who became quite phobic of a frozen child part and the 'stories' she held. Just as in the top-dog/underdog concept, even when there is awareness between the dissociative parts, they may be antagonistic towards one another. Inner conflict characterizes the process of dissociative fragmentation.

Disconnection between self-states is a key consideration in understanding the difficulties that trauma clients have in resolving conflicts,

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mobilizing or making decisions. However, it only takes a little imagination to recognize that parts are actually resources. What is essential to understand is the *creative and defensive role that each and every part represents and the positive contribution they make to the life of the victim*. The implication of this for therapy is that by understanding the parts and the relationships between them you arrive at a new appreciation of the whole, which can then function with fluidity and coherence.

One thing that is missing from the Structural Dissociation Model is the concept of a healthy adult self. It is, after all, a model of dissociation and not one of healthy functioning. The implication is that however the self was organized before the trauma took place, it has been completely destroyed by those events. This is an unnecessarily pessimistic view of the situation. It may be that to some extent the healthy self is subsumed into the part that continues as if nothing has happened, called the 'Apparently Normal Personality' in this model. But there is no recognition that there may continue to exist a part of the individual that has not been affected by the trauma, a part to which the victim can return, or use as a guide or a resource in the process of their recovery. A view more consistent with Gestalt values of health is offered in Schwartz's Internal Family Systems Model, whereby a leadership role can be taken up by a part. Using the metaphor of an orchestra, he suggests that 'the individual musicians are analogous to the parts and the conductor is the self' (1995: 39). No matter how tiny that part may be, clients can often access the notion of a healthy adult 'conductor' self in themselves, which can help to establish the dual awareness perspectives of 'present and past', 'adult and child'. It is integrative to re-establish contact with a pre-traumatized self, and the idea that not all of them has been damaged by the trauma gives rise to comfort and hope.

Experiment

Just becoming aware of different parts can be very helpful. When you are with a client who has experienced trauma try to simply track their shifting self-states, as they report what they have done, felt or thought. Do this by telling yourself as each new figure emerges: 'That's a part, that's another part, that's another part' and so on. You don't need to do anything or to say anything about what you notice, just allow it to register in your awareness. It is suggested that you maintain a steady eye on this shifting of self-states throughout a session. Later, reflect on what you noticed, what helped in the experiment and what patterns emerged, maybe making a few notes about them.

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Dissociation and relationship

The levels of structural dissociation described above can be likened to boundary issues. The greater the trauma, the greater the boundary difficulty. In Gestalt terms, where 'self' is created at the boundary with the environment, dissociation has everything to do with contact boundaries, presence and availability for contact. Indeed, the victim who dissociates is actually redefining a boundary, effectively removing their self from an intolerable situation; there is a strong sense of 'NO!' in this process which needs to be made explicit. For someone who is deeply traumatized, the catastrophic sense of alienation depicted in the opening quote of this chapter underlies *all* interactions, *all* self-concepts, *all* hopes, *all* longings for connection.

When abuse or trauma has stemmed from childhood, the victim may never have felt a true sense of belonging: 'Trauma . . . individualizes us, but in a manner that manifests in an excruciating sense of singularity and solitude' (Stolorow 2007: 41). Delisle comments poignantly that 'Often these subjects have not been held closely enough to sense that they are in the world' (2011: 83). 'Profound isolation, longing and loneliness are hallmarks of traumatised people, symptomatic of victimisation' (Hillman 1996: 54).

The Gestalt view of relationship has long been that we are hard wired for contact, and this view is confirmed time and again by learning from neuroscience (Siegel 1999; Schore 2003; Gerhardt 2004). Bromberg considers dissociation to be an interpersonal process (2001: 277), and this idea is taken up again in Part 3 of this volume. It links with notions of trauma by betrayal and dissociation maintaining attachment. Abandonment of the authentic self reflects and compounds the unbearable experience of actual abandonment in the wider or historical field.

There are several possible boundaries that we are referring to in relation to the organism and environment. These include skin, safety zone, personal space, sex, aura and the limits of the window of tolerance, affecting relationship with others in all areas of life. At different stages of therapy other boundaries (apart of course from sex) may become relevant, but for the most part our concern is with establishing a safe enough personal space in which the client can be present. In this regard, we recall that therapeutic presence can be either a potential trigger or a support, and there is often a very fine line between the two.

Trauma clients are often exquisitely sensitive to distance and closeness, notwithstanding the distorted perceptions of distance that can arise in dissociated states, and may have intense reactions to signs of intrusion

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however subtle. Sometimes clients need to manage the therapeutic space in terms of distance between them and their therapist by asking the therapist to position their chair 'just so', maybe even to within a few centimetres in order to begin to feel safe. A wise therapist will check this out with extremely traumatized clients. Therapists can learn to sense a kind of energetic bubble in their clients which they can find the edges of, an embodied sense that they do not have permission to come closer or an awareness that they have already invaded that space (Cook 2012: 16). Carefully calibrated, it is possible to ensure that distance is 'not too much' and 'not too little'. Of course when the wider field is not perceived as receptive to trauma or intense distress, victims tend to withdraw and maintain secrecy about their experiences.

It is an all too common experience for trauma victims to be disbelieved or to have their suffering denied or misunderstood. This may well be a consequence of the 'not quite present' quality of the victim; there is not enough of them there to be taken seriously. A tendency towards immobilized defences lays the victim wide open to misunderstanding and sadly sometimes to be further taken advantage of. The more functional part of the personality too often 'goes it alone', sometimes disavowing all need for contact if the traumatized 'attach' response is dissociated from awareness. There is much deep mistrust in traumatized people, which corresponds to their fundamental lack of safety in the world. Dissociation also protects attachment relationships, keeping 'bad' aspects of the relationship out of awareness; without this Stockholm Syndrome would not be possible. Disclosure and the search for connection and support involve the loss of these hard-earned survival-based creative adjustments.

Among these clients are those who are fiercely independent, highly defended against exposing their vulnerability and pain. Unaware of their window of tolerance, they may manage extraordinary, almost superhuman amounts of stress without asking for help. They haven't had the chance to learn what support is, that in healthy relationships people reach out to one another. Others are acutely vigilant for signs of abandonment or rejection and may resonate with the therapist's changing presence or availability for contact even before they are aware of them. Trauma clients need to learn to tolerate aloneness and solitude which can regulate arousal, decoupling these situations from associations with abandonment.

A further consideration with fascinating implications comes from neuroscience. Research highlights a qualifier to the relational perspective, presenting a challenge for Gestalt to integrate into established thinking about self, other and contact boundaries. We now know that empathy, a relational skill, can be developed through the *individual* practice of

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mindful awareness. Siegel states this: 'We can . . . imagine that the *social nature of our brains may have something to do with our minds in solitude*' (2007: 170, my italics). What this seems to suggest is that a process of neural reconnection takes place in solitude which helps create the conditions for social connection. The need is to restore the wiring for contact. But if dissociation is an interpersonal process in its genesis, maintenance and in recovery, then we can postulate that this neuronal repair in solitude is also a function of the relational field. It is in neither the realm of the individualistic paradigm, nor that of the other, but both. The Gestalt field perspective is that nothing, not even thought, happens without reference to the field: '*Movement of the flow of states of mind can involve activity both within the mind itself and in interactions with other minds*' (Siegel 1999: 320, original italics).

Supporting contact

Therapy with trauma victims needs to be seen as a kind of rehabilitation, in the sense that the word refers to indwelling and belonging. 'Rehabilitation is to restore someone to his/her rightful place in the community after some kind of disjuncture or relational rupture' (Levin and Levine 2012: 8). The task is to support developing integrative capacity and a reclaiming of self in the world. At the same time the creative defensive role of dissociation needs to be seen and understood, and as ever in therapy the defence needs to be honoured rather than dismantled. As Bromberg puts it, the paramount need is to 'preserve the dissociative structure while surrendering it' (2001: 199). There are three principal areas calling for attention in therapy with dissociative clients. The first is to learn the skill of staying present, the second is to work with fragmented self-states and the third is to reclaim a healthy sense of body. These will be examined in turn.

Dissociation by its very nature moderates presence; they are two opposing and contradictory forces. So presence is therefore the much needed missing polarity to dissociation. Therapists must foster a range of ways in which dissociative clients can return quickly and safely to the present. Initially, these ways will occur naturally in the therapy setting, but the client usually finds it impossible to translate the skills and techniques into everyday life settings. Over time, even many months, these skills become more integrated and easily accessible for clients. A first step may be to learn whatever strategies the client already uses to bring themself more into contact with present reality, preference being given to soothing and grounding activities, and which are positive rather than self-destructive.

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Experiment

Learning to be present

Notice three objects that you see in the room and pay close attention to their details (shape, colour, texture, size, etc.). Make sure you do not hurry through this part of the exercise. Let your eyes linger over each object. Name three characteristics of the object out loud to yourself, for example 'It is blue; it is big; it is round'.

Now notice three sounds you can hear in the present (inside or outside the room), and pay similar attention to them, listening for their qualities and naming their characteristics.

Now touch three objects close to you and describe out loud how they feel.

Return to the three objects that you have chosen to observe with your eyes. As you notice them, concentrate on the fact that you are here now with these objects in the present, in this room. Next notice the sounds and concentrate on the fact that you are here now in the room with these sounds. Finally, do the same with the objects you have touched.

(Adapted from Boon et al. 2011: 5)

Working with clients, repeating this kind of anchoring process becomes an integral part of therapy, and there are many possible variations of it. It is another means of bringing the client back into their window of tolerance, and is also a form of concentration and mindful awareness training. One feature of this kind of exercise is that it is very specific and concrete, which helps to reduce dissociation. Another concrete strategy is to ask clients what percentage of them is present in the room right now, and to enquire about what would help increase this, even just a little.

Contrary to what might be assumed, it is important to address the issue of part selves directly in therapy. Clients need to have their process confirmed and normalized, and their resources acknowledged. We need also to be clear with clients about what we mean by integration between parts. The goal of this work is to 'repair the short circuits, not to remove or replace parts' (Ross 1997: 304), enabling a fluid movement between self-states. It is this fluidity that is the hallmark of integration or self-coherence. Sometimes the trauma literature suggests that integration is a final merging of all the parts into a 'single' unified whole. This is a reductionistic view of self and does not fit comfortably with a view of self as a complex process. Once clients are comfortable and familiar with parts

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they tend to be reluctant to give them up. It is actually necessary for parts to 'come to attain a clarity and personal significance that gradually alleviates the patient's previously held sense of confusion about who he "really" is and how he came . . . to be this person' (Bromberg 2006: 290), which is in the service of wholeness.

If the self can be disassembled by experiences that alter connections, presumably it can be reassembled by experiences that establish, change or renew connections (LeDoux 2002: 307). Therapists need to elicit awareness of parts together with a compassionate understanding of their functions in order to achieve a greater degree of co-consciousness. Access to this can be supported by means of enquiry into the fears and needs of parts using tight therapeutic sequencing (Polster 1991). We cannot work with parts alone but have to take into account the way they are organized (Goldstein 2007: 116); that is, we must understand the relationships between them as well as their contributions to the whole. The client needs to learn to tolerate the underpinning internal conflict between parts about integration (Bromberg 2006: 69).

To do this, it is helpful to support an inner dialogue, encouraging the client to bring to the therapist, rather than to the empty chair, the disparate parts (Spagnuolo-Lobb 2009: 118). This does not mean that the therapist has a 'separate' relationship with each part; the healthy adult self is best strengthened by encouraging this part to narrate on behalf of the others. Clients can learn techniques for managing their parts such as asking the distressed parts to 'drop into their feet', which sounds odd but makes sense to many clients, asking a perpetually vigilant insomniac part to let the 'others' go to sleep, or when there is sufficient co-consciousness to imagine the parts having a meeting around a table. Little is actually going to move forward in life without the agreement of all the parts, or sabotage will be inevitable.

It is not possible to work with dissociative processes without attending to the body. More complex clients may need access to other complementary bodywork therapies such as Cranio-Sacral, Rosen massage, Alexander or Feldenkrais. It is necessary to talk directly about embodied experience because it can challenge depersonalization and fears that 'the body is too damaged to be included in the recovery process' (Goodwin and Attias 1999b: 170). Further it is helpful to 'rediscover a middle ground between complete dissociation and unbearable suffering inside the hurt body' (Goodwin and Attias 1999b: 172). The word to emphasize here is rediscover – bodywork in dissociative processes is about reclaiming what has been disconnected from. The skills of working with the dissociative body are similar to those highlighted throughout this book: phenomenological tracking to support awareness, slowing down or energizing the process to manage arousal (Ogden et al. 2006), and experiments in directed

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awareness. Reconnecting with the body requires 'careful, non-judgemental, mindful attention to feelings, thoughts and body sensations as they arise in the present moment' (Sapriel 2012: 114).

However, there is a key point which therapists can bear in mind when building experiments. When working with helpless responses it was shown that movement is a key to recovery. Movement by definition involves the use of the limbs: the periphery of the body. In dissociation, however, attention needs to be paid in addition to the core of the body. By this is meant the anatomical structures pertaining to the trunk, particularly the lower trunk, around the centre of gravity just below the navel. Kepner makes a counter-intuitive point that a loss of sense of boundaries relates to a sense of displacement from the axis of the centred spine (2002). Exercises derived from pilates, yoga, and tai chi are helpful in establishing an embodied sense of the core. In order to restore the capacity to manage intensity from a numb place it is necessary to grade and pace the work carefully – akin to developing experiencing functions (Kepner 1995: 78). There needs to be a gradual shift from just noticing sensations and processes to dropping into a deeper level of awareness (see Chapter 5). Trauma clients need to be able to be present not merely to the here-and-now but to the lived experience of an embodied self.

Case Study Part 3

There was something remote about Eve, a combination of her low energy, the protectiveness carried in her voice, her functional use of language and her guardedness with me. I wanted to reach out for more contact with Eve, but felt subtly pushed aside and learnt that she had few expectations of having her needs met relationally. Eve said that she felt abandoned by other potential sources of support. She had no close friends and excused herself from social events at work and at Freya's school. She experienced herself as alienated by virtue of her trauma. Away from the safety of her home she felt, to use her words, 'as though I'm watching a film, and I'm not in it', the experience of derealization.

This was something we worked with in the immediacy of the therapy setting and Eve became more able to sustain her growing presence, which we could monitor together. We worked directly on many things that could help her engage, in the therapy room, in her external world, and importantly in terms of her inner experience. There were moments, particularly when she went into a state of collapse, that Eve reported my voice becoming very faint to her, and said that she was floating away from her body. Therefore we worked in a sustained fashion to support safe body awareness and feelings of strength and fluidity, and to reconnect Eve

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with a sense of bodily competence. Eve used the additional support of a massage therapist and yoga classes, and returned to her former interest in swimming as the closest she could come to the safe experience of diving.

Eve's struggles with anger were very much at odds with her tendency to give in to others. Along with psychoeducation about trauma and dissociation which Eve found helpful, I introduced the language of parts to help shed light on Eve's conflict. We recognized that there was a dimension of attachment in her behaviour towards her boss, that she needed him for the security that came with the job, regardless of his treatment of her and the stress she often felt. It was important to honour the purpose of her attachment and at the same time see it as an attempt to keep herself safe that wasn't working well. Eve understood how submissive she had needed to become in the face of terrible threat and we worked with different parts to establish inner dialogue. Eve noticed that some of her confusion cleared when she could appreciate that aspects of her personality were both courageous and vulnerable.

As therapy progressed Eve began to feel less isolated and more engaged with the outside world. She said that she could see more clearly and commit herself better. 'I no longer felt mad or that I was a square peg in a round hole', she told me later. Still, she remained extremely anxious about mixing with other people, and was able to notice the inner arguments which kept her from moving forward. It was most important that Eve was learning to pay attention to somatic signals and could interpret their meaning with some accuracy and act appropriately.

Summary

Dissociation is a natural biologically driven function, which we all use in order to switch off from boring or stressful situations, to daydream or to lose ourselves in a book or film. This is quite different from the dissociation that results from trauma, which may involve either depersonalization or derealization, or both. In this kind of dissociation there is a marked loss of contact functions, and a sense of the energy of contact being withdrawn. Dissociation is a major modifier of contact, redefining the boundaries and sometimes putting the client out of reach. A level of dissociation is likely to be found in the majority of trauma clients. For the client this can result in feeling as though they are deeply disconnected and going through the motions of life. The role of therapy is to help create a way back, to reclaim the body and establish a more cohesive sense of self.

Dissociation is a creative adjustment par excellence, enabling the victim to continue with some semblance of normality, though at

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enormous cost. Trauma victims sacrifice a cohesive and integrated sense of self and flee embodied life in order to survive threatening levels of inner conflict and intensity of feelings. The Structural Dissociation Model explains the process of fragmentation of the personality. Primary and secondary structural dissociation are the two types most commonly seen in clinical practice. These involve the splitting of the self into traumatized and functional 'parts'; in complex trauma or Secondary Structural Dissociation, the traumatized roles are reflections of the five defensive functions under threat: fight, flight, freeze, submit and attach.

The sense of alienation in dissociative processes can be quite profound; alienation from self, body and from other. The inherent distancing in dissociation is a self-imposed boundary which isolates rather than includes. Restoration of connection involves work on different levels, harnessing the potential integrative capacity of the fragmented self-parts and of the body in order to increase connectivity with the wider field. Establishing compassionate understanding of the contribution of each part and of relationships between them, called co-consciousness, together with increased capacity for inner dialogue is essential. In working to reclaim the sense of the body as a safe dwelling place and container, work on the core of the body is needed.

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9 From shame to acceptance

This chapter explores the experience of shame as a particular response to trauma. It looks at how shame can be understood as an attack on the self, often mirroring the attack of interpersonal trauma. Perspectives on shame, blame and responsibility in the context of trauma are discussed. The chapter moves on to issues of self-harm and suicidality, and the somatic response to shame. The experience of shame is placed in a trauma field context and there is an exploration of the dynamics that operate to keep shame in place. Acceptance is offered as a polarity of shame and ways of increasing this are explored, including the role of compassion and pyschoeducation.

Shame is a universal experience that links in particular ways to trauma. Bromberg considers the emergence of sudden shame to be a 'threat equal to that of fear' (2011: 23). Although its seeds may lie dormant from before birth, shame is an emotion that develops alongside an emerging sense of 'I' from about 18 months to 5 years of age, an aspect of omnipotence and healthy narcissism. It is this budding 'I' that becomes vulnerable to shame, when one or more aspects of the 'self that I am' is not seen, acknowledged or prized by others. Gestalt therapists understand shame as a creative adjustment; a reorganizing of the contact boundary because of a rupture or threat of rupture between self and some aspect of the wider field. Shame is also linked in Gestalt to theory of self, and fragile self-process: the self that is formed in contact at this acutely sensitive boundary (Lee and Wheeler 1996). The boundary as reorganized is fragile in part because of the fixed gestalts that constitute it; the more fixed or rigid a structure, the more fragile or brittle it becomes.

Shame prone clients are highly attuned to relational cues about the receptivity of the field, attention often turned to the needs of the other as a substitute for getting their own needs met. Poignantly, such attunement on the part of the trauma victim is the inverse of their experience of mis-attunement by others, and leads them to draw damaging conclusions

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about their intrinsic worthiness. 'She [sic] is thereafter in doubt both as to her own legitimacy as a person and the reality of her internal experience' (Bromberg 2011: 43). The forcefulness of the emotion is such that a range of defences against it come into play, including withdrawal, denial of desires, attack against self and other, perfectionism and defensive justifying; retroflection is a creative adjustment.

The three major themes of fear, helplessness and disconnection in the lives of trauma victims become constellated around shame. That is not to say that these clients come into therapy with awareness of shame processes; for the most part they tend to avoid recognition of this intense emotion which must be hidden and which in turn masks authentic contact. They may give other names to their experience which belie their sense of unworthiness, self-disgust and humiliation, which all come under the umbrella of shame. There are mutually reinforcing shame loops at play: shame as an organizer of self in relation to other of which one must not yet be aware; shame for feeling shame; shame for self-expression and shame for hiding. Personal history, current situations and internal and external fields (Delisle 2011: 21) all clash in the experience of shame. In particular, relational styles informed by the 'there and then' field are internalized; perceived expectations become the template for contact. Shame processes are embedded in fear through hypervigilance, in helplessness via the locus of control shift, and in disconnection through deep sense of not belonging. Because of psychophysiological similarities between them, 'there is an *intrinsic* association of shame and trauma ... [shame is] an almost structural component of trauma' (Levine 2010: 60, original italics). In trauma, shame is a given.

Shame through the lens of trauma

The experience of shame is searingly visceral, complex and multifaceted, 'usually continuous with moments of more intense pain' (Orange 1995: 97). It is closely related to physiological systems concerned with threat and fear: a 'threat that we are about to be violated' (Bromberg 2006: 190). There is an extremely high potential for reactivating trauma responses when an environment is perceived as shame inducing. First, trauma clients orient defensively towards potentially shame-inducing situations, becoming hypervigilant for signs of receptiveness or dismissiveness of the field. They are exquisitely attentive to signals of rejection more than to signals of acceptance, which may often be misconstrued or mistrusted. The expectation of being shamed escalates, which tends to preconfigure the field. Bringing to the encounter, as trauma victims do, the experience of being overpowered by some force other than themselves shapes their physiological, psychological and emotional ability to make contact.

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The sense of shame is itself overpowering and as difficult to regulate as other trauma responses. Layered into this is shame for the inability to regulate, for not having 'got over it'. Shame relates to the states of high arousal and intrusion so characteristic of trauma and naturally comes to be avoided. Trauma victims can experience shame for their flashbacks, nightmares and intrusive thought processes as well as for their compensatory avoidance and regulatory strategies such as self-harm, distressed eating, obsessive rituals or substance abuse. Furthermore, they can have vivid flashbacks to previous shameful experiences (Boon et al. 2011: 289), including the traumatic event itself. For some victims there are such intolerable levels of shame and disgust at what was actually done to them, most particularly – but not only – in respect of sexual trauma, that avoidance may be their best defence (Turner et al. [1996] 2007: 543).

The correlation between shame and helplessness has already been mentioned in Chapter 7. The relationship between the experience of helplessness and physiologically based immobilized survival defences was explored through the lens of creative adjustments. Immobilization is experienced as a *failure* to defend, failure being so bound up with shame. Sadly, trauma victims are vulnerable to feeling shame for so much that they have done in the service of survival. Any healthy sense of potency is destroyed, an annihilation of any memory of having been capable, which may well be referred to as having belonged in 'another life' or to a sense of having been a different person 'back then'; then, but not now, no longer. The wounds of shame feel so permanent that there is no hope and they feel unworthy of healing contact. In their own eyes, and often in the eyes of others these shame-prone clients believe themselves to be weak, unable to stand their own ground.

Drowning at times in an ocean of shame, with an eye constantly on the next incoming wave, trauma clients habitually refer to others by means of comparison: others who keep things in perspective, who manage their emotions, who don't seem out of control. The paralysis of helplessness is reflected in chronic indecision, for fear that the 'wrong' decision might be arrived at. When the validity of one's existence is threatened, the abilities and rights of others assume a greater significance – the locus of control shift. Speaking of the experience of children, but no less applicable to adults, Bromberg comments that: 'The other holds the power to destabilize the child's mental state by rupturing a relational connection that organizes the child's sense of self-continuity' (2011: 43). The conclusion that 'Something bad has happened to me therefore I must be bad' is common. Kepner, however, helpfully reconceptualizes this as: 'I feel bad about what was done to me' (1995: 38). The experience of helplessness can be seen in the strong sense of injustice that many trauma victims experience. Indeed, viewed compassionately, shame is an indicator of sensitivity towards basic unfairness in the world.

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Traumatic experiences evoke existential crises for many victims: shame-laden cries of 'Why?' and 'Why me?' may go unvoiced, unheard or unanswered, but are nevertheless central and intrinsic questions for these individuals. Clients need to gain a sense of order in a world that seems unordered, and explanations may be a search for a sense of control and safety. For those whose spirituality or faith system is threatened by trauma there may be a sense of abandonment by their God: 'How could He let this happen to me?' The pull to make sense, to explain to the self and to others how their world has changed so dramatically, to find words for the experience, to be understood and therefore to be received and to reconnect is strong. These are all ways in which the trauma victim seeks to mitigate the feeling of shame.

The rupture of the boundary between self and other, often a pervasive sense of being 'different', which is implicit in trauma, is experienced as both deeply alienating and deeply shaming. The conclusion drawn may be that one is so disgusting as to be unworthy of belonging in the world. Trauma victims tend to find their dissociative experiences confusing and inexplicable. In addition, there may be dissociative parts of the personality which are shaming. In any victim of abuse or trauma there may exist a persecutory part that seeks vengeance on those who have caused their suffering, and it can be challenging for clients to accept and integrate these powerful forces. Shame is so intolerable that it may itself become dissociated, reorganizing the sense of a coherent whole (Bromberg 1998; 2006; 2011). Trauma, dissociation and shame are inextricably linked; we can start at any point and arrive at the others.

There are some final considerations of shame that are particular to trauma. Shame is a rather different experience for people whose traumatic experiences have been as a result of accident or natural disaster and those who have suffered deliberate interpersonal attacks of some description in which betrayal of trust is often central. In the case of the former, it is now recognized that the availability of support in the immediate aftermath predicts recovery; in other words receptivity in the relational field is crucial. If attachment bonds are not destabilized by misattunement or misunderstanding the individual may fare well in the long run. However, adult traumas of this kind may reactivate earlier attachment difficulties, and feelings of shame may emerge. Additional shame may be caused when a perpetrator is known to the victim, when there may be concerns that in some way the victim asked for attack or could have seen it coming. Further, for some the issue of survivor guilt may greatly impinge on recovery: 'Feelings of guilt are especially severe when the survivor has been a witness to the suffering or death of other people. To be spared oneself in the knowledge that others have met a worse fate, creates a severe burden of conscience' (Herman 1992: 54).

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Shame as an attack on the self

The link between shame and narcissism can be developed further when trauma is conceptualized as narcissistic injury of a particularly severe kind, the wounding of the self. There is a difference between the experience of a traumatic event and shame, though the one may contain the other. Traumatic events are threats to bodily survival, and the limbically driven responses serve to optimize the survival chances of the physical organism. Shame, on the other hand, is primarily associated with an attack on the self – a threat to the integrity of personhood and identity which 'typically calls forth dissociative processes to preserve self-hood' (Bromberg 2001: 295). To the degree that the victim identifies with the trauma, the sense of self is subsumed by it.

Self as a process at the contact boundary needs by definition to sense *into* that boundary in order to emerge. In many traumas, however, the boundaries of personal space, skin and even of bodily orifices are violated, relinquished in the face of inescapable disaster or the compulsive desires of another to humiliate and overpower. Trauma clients often have real difficulty locating appropriate boundaries, of knowing where 'they' end and the 'other' begins. This is more than a dissociative perceptual difficulty; it is often a shame-bound disowning of the personal right to determine their own boundaries, a marker of the locus of control shift. There is not only a disorganization of the self/other boundary: other experiences of self are threatened by shame processes. Connected with the sense of being 'defective' and unlovable is a denial of the basic human right to a place of safety; these are fixed relational gestalts. Self-concept is radically altered by trauma. Bromberg considers that 'the struggle to *self*-reflect is mentally disorganizing' (2011: 43, my italics), while Schore's contribution is that shame involves 'a painful, *self*-disorganizing internal state that cannot be regulated' (2003b: 175, my italics). Van der Kolk et al. state:

> Traumatic experiences are not only processed by means of currently existing mental schemes, but they may also activate latent self-concepts and views of relationships that were formed earlier in life. This activation of latent schemes is particularly relevant for people with prior histories of trauma, even in those who subsequently have been able to make a successful adaptation. When trauma activates these earlier self-schemas [fixed relational gestalts] these will compete and co-exist with more mature schemes in explaining cause and effect relationships in regards to the trauma. These different, and often competing mental schemes then will determine the psychological organization of the traumatic experience.
>
> (van der Kolk et al. [1996] 2007a: 432)

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Fundamental to the emergence of shame is the individual's loss of 'ability to retain a sense of past successes' (Orange 1995: 103). The conclusion that 'I am no good' is painfully compounded by this sense of loss, the perception of self being skewed in favour of the narrow focus of the orienting response. Yontef describes shame as 'a learned sense of not identifying with self as is' (1996: 354). Self-concept also has a relational function in shame, typically experienced as self-consciousness in which the individual sees themself through the perceived critical eyes of another. However, self-concept tends to be rather narrowly constructed, and does not define who we are. From this we can conclude that by widening the focus to include other potential configurations of self, growth may become possible.

Shame, blame and responsibility

Clients who are prone to shame for whatever reason tend to take a disproportionate degree of responsibility for the difficulties in their lives. When this happens in relation to trauma, the self-blaming sense of responsibility is even more pronounced. The locus of control shift not only locates power in key people in the wider field, it tends to locate blame in the victim. Responsibility becomes polarized, especially given that it is characteristic of perpetrators to deny responsibility. Therapy often involves a reorganization of the complex responsibility boundary, accompanied by a reorganization of power and control. To re-align boundaries of responsibility means relinquishing some of the small degree of control that might have been something of a resource previously. Phenomenologically, guilt is a less intense emotion than shame. It may therefore be more regulating to assume responsibility for the traumatic event.

Shame is an emotion that is learnt in relationship; we are not born with it. It is through the lens of the co-created relationship that the fixed gestalts which maintain the dance between victim and perpetrator are best understood. Perls et al. refer to this thus: 'you are creative in your environment and are responsible for your reality – not to blame, but responsible in the sense that it is you who lets it stand or changes it' ([1951] 1998: 216); by creative they refer to co-creation. Co-creation points to an uncomfortable realization: trauma victims had a part in their trauma. This does not in *any way* apportion blame to them nor suggest *equal* responsibility; the participatory part may be a very tiny percentage of the whole. However, in Gestalt thinking, the notion of 'You made me do this' could no more apply to a perpetrator's view of the victim than vice versa. Responsibility is shared and it would be nonsensical to suggest that anyone other than the victim must take ownership of their helpless response, or the familiar repetitions of their past, for example. For some victims, acceptance of their small part in the

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relationship can bring relief; it is far easier to forgive oneself for something small, reasonable and proportionate than for the whole catastrophe, and more true to their subjective experience. It is a more active position to take than that of being unable to do anything about a situation.

An even more sensitive issue exists for some victims of sexual assault or abuse: that of having become aroused during the attack. The belief that goes with this is along the lines of 'If I enjoyed it, then I was to blame; I consented', without recognizing that the body is programmed to respond to certain kinds of contact by becoming aroused, regardless of context, relationship or consent. This can create seemingly intransigent impasses in therapy, in particular for clients who direct their anger towards themselves instead of redirecting it appropriately towards those who have hurt them. Later, victims of sexual trauma may become ashamed and avoidant of their sexual desires, causing relational difficulties. Trauma clients tend to lack compassion for their wounded self. For example clients sometimes feel intense self-attacking shame about crying when tears haven't been allowed in the past. Effective work with shame reduces blame and increases choice and appropriate responsibility. After all, taking responsibility for the past is responsive rather than collusive or **confluent**; it allows for differentiation to arise from the alienation.

Not only do trauma victims identify with their trauma and a sense of victimhood, they may also identify with the person who has caused their hurt, be it the perpetrator of an assault or 'the driver of the other car' involved in an accident. For a woman who has been raped, for example, there may be a complicated attachment to her rapist, a greatly feared but ever-present intruder who comes into her life by means of flashbacks and other trauma-generated experiences. These attachments lie on a continuum, a most extreme form of which can be seen in Stockholm Syndrome, where a hostage may fall in love with their captor. Identifying with victimhood is part of the narrative: 'I'm worthless' becomes incorporated into the sense of self, and gets relationally polarized dynamically on the part of the perpetrator as 'No one messes with me'. Shame is part of a process that maintains the repetition of the trauma. In a complex interplay between the layers of helplessness, fear and dissociation, the abuser's treatment of the victim can become the standard by which the victim treats him or herself. Trauma victims may come to see themselves as their abuser sees them; their words, threats and displacement of responsibility become a kind of 'truth' for their victims, who make them right and give away their power.

Shame brings with it the harshest judgements of self, sometimes in the form of vitriolic and vicious self-attacks, an extreme form of the top-dog/underdog dynamic. Self-judgement can make a new shape of chaos making it more containable. The victim may interpret the trauma and its consequent suffering as a punishment for not actively defending themself

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or for putting themself in a vulnerable position. It can be hard to accept that they were simply in the wrong place at the wrong time, for to do so confirms a belief that the world is unpredictable and sometimes random, over which they had no control. Self-blame permits 'an illusion of potential control. Ironically, there is evidence that rape victims who blame themselves fare better in the long run than those who do not assume this false responsibility' (van der Kolk and McFarlane [1996] 2007: 15); it allows the locus of control to remain internal and prevents helplessness.

Shame-full bodies

To have experienced overwhelming trauma means for many victims that they must bear the scars of that trauma, whether visible or invisible, psychic or bodily. For some, these scars are so unbearable that they must be hidden and disavowed: 'I hurt too much to bear to let you see'. Pennebaker reports that trauma victims who do not talk about their experiences tend to have more physical illness, and we can imagine that shame plays a part in this sickening silence (2000: 309). Victims may be so acutely conscious of this enduring burden of shame that they come to see their physical selves as sick, defiled, toxic or violated, and it may feel better to pretend that the body and its needs don't exist. There can be a rawness in the pain of trauma, as though the skin does not exist. 'Because of complex boundary problems, there is severe confusion, and patients may experience their own wounded self as fatally toxic if seen . . . and the reality of the abuse as a fatal image that must be concealed' (Attias and Goodwin 1999: 161).

Body shame is a key factor in reducing self-care and body awareness, and there is a dilemma between the need to feel invisible and feel seen. Schore says of shame, 'perhaps more than any other emotion [it] is so intimately tied to the physiological expression of a stress response' (2003a: 154). Shame triggers defensive responses of blushing, postural change, reduced eye contact and withdrawal which are different from the instinctive survival responses of fight, flight, freeze, submit and attach. In shame there is a loss of footing, one cannot stand one's own ground because one is standing partly on the ground of the other.

Experiment

With your shoes off, stand upright, feet hip width apart, with your shoulders relaxed and knees unlocked. Attending to your breathing, allow a softening in your body on your exhale, allowing a sense of

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your whole body breathing. Bringing your attention to your feet, and to the contact between the soles of your feet and the ground, notice the areas of your soles where the contact is most vivid and the areas where there is less contact. Compare left and right foot, noticing the differences; it is rare for both sides of the body to be the same. Following your exhale, begin to allow your weight to drop through your body into your soles and the ground underneath, a sense of yielding into the ground.

Now increasing your attention to the soles of your feet, add a small push from your soles as you inhale, clarifying your sense of contact with the ground. Widen your focus of awareness to include your whole foot, your ankles, calves, knees, thighs, hips, spine and whole body, alternating pushing and yielding as you continue to breathe in and out. Stay with this experience for a few moments, resting in it, enjoying this natural state perhaps. Now take a step forwards with one foot only. Notice the differences, paying close attention to how your focus changes and how you now orient and reorganize yourself.

Shame and self-harm

There is a close relationship between shame and self-harm. The experience of abuse or early trauma increases the likelihood that the victim will self-harm in adulthood (van der Kolk et al. 1995). To feel endlessly terrible about oneself is injurious to the sense of self, and becomes externalized in self-inflicted acts of violence against the body. This may include pursuing injurious relationships such as engaging in reckless sex. Self-harm is a reflection of the degree of pain trauma victims feel. 'This state of shame . . . may ultimately be followed by self-destructive impulses . . . to do away with the self in order to wipe out the offending, disappointing reality of failure' (Kohut 1971: 181, cited in Orange 1995: 100). This is not to say that incidents of self-harm are necessarily triggered by states of shame, at least not overtly.

However, the desire to attack the body speaks clearly of a dissociated lack of acceptance of embodied life. Fisher makes clear the link between self-harm and the need to relieve tension in those who have been abused and have not learnt to seek soothing from others (undated paper, 'Self harm and suicidality'). For some, self-harm is related to the reversal of more immediate relational concerns, by providing an alternative to dealing with conflict, the setting of boundaries and the risk of relational rupture. Shame is a relational phenomenon which gives rise to physiological

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reactions. It is a state of emotional and physiological dysregulation and, as such, episodes of self-harm occasion the release of endogenous endorphins which substitute for the attuned other who is unavailable (Cozolino 2002: 278–9). Self-harm can 'paradoxically act to shield the individual from overstimulation or attack (by putting the self in control of the infliction of pain)' (Attias and Goodwin 1999: 161). I remarked to one client that the way she treated herself was reminiscent of the way her abuser treated her. 'Yes,' she replied, 'and it's me who chooses it.'

The physiology of shame

The experience of shame is agonizingly physical, a more visceral experience than guilt, a 'powerful, preverbal, and physiologically based organising principle' (Cozolino 2002: 195). Schore (2003b: 154) describes some of the acute physiological and phenomenological features of shame: greater body awareness, intensified perceptual functions, uncoordinated motor movements, cognitive impairment, blushing, cardiac deceleration, thus implying there is a 'more primitive, biological base'. There is a cyclical process involved in shame: it is a process of dysregulated arousal and of failure to regulate. It is a state of heightened sympathetic arousal, accompanied by self-consciousness and hypervigilance. Blushing is caused by the dilation of small capillaries of the face, triggered by sympathetic arousal of the ANS (Cozolino 2006: 160), and may serve to reduce self-exposure and self-exploration (Schore 2003b: 154).

The relationship between shame and fear or threat is clear. Panksepp considers more specifically that shame may emerge from 'separation distress' systems in the brain (1998: 27), the relational and attachment function. While he regards shame as a secondary 'cognitive-type' emotion, he links it more critically with more primitive emotional layers of the brain (p. 301). Cozolino proposes that shame is a feature of a bias in the brain towards right-hemisphere and more 'negative' emotions (2002: 119). 'Prolonged and repeated shame states result in physiological dysregulation and negatively impact the development of networks of affect regulation and affect' (p. 194). In addition to understanding shame as a problem associated with regulation, there may be a physiological correlate to the feeling of being toxic or dirty that so often accompanies this feeling. In the muscular contraction that accompanies shame states and heightened arousal, toxins can be trapped in the muscles, the literal presence of something bad in the body. However, on a positive note, Attias and Goodwin observe that 'the bodily suffering is not as endless or as shameful as the patient's traumatic cognitions have constructed it' (1999: 172), or at least it need not be.

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In an unreceptive world

Kepner writes that shame is not simply an emotion, it is an experience of the field (1995: 39). Shame arises when someone expects or needs attunement and meets instead disapproval and misattunement in the eyes of the other. The arrival of an unwanted baby into a family that is too fragile, disorganized or fragmented to welcome the newcomer is a recipe for shame; in such cases shame exists almost at a cellular level at the very core of the child's being. When parents themselves carry unbearable amounts of shame, the feeling is transmitted across the generations; it is the ground the client comes to stand on. Although they are highly field sensitive and dependent, shame-prone clients do not check for here-and-now evidence in the wider field, preconfiguring relationships through previous experience of shame-laden trauma. Lee states that shame is a 'distortion of the self -other boundary: *the need that is not received by the other is disowned and made "not me"* ' (1996: 9, original italics). One woman was told by a colleague, 'Oh, you are lucky to have been raped, I've always fantasized about being raped', evidence of the degree of misattunement of the field, and the inability to separate fantasy from reality. Shame is therefore a conclusion you come to about yourself and your needs in an unaccepting world; a feature of the need to make relational bonds, of defensive attachment systems, and of the breach of those attachment bonds.

Shame calls out to be received by the other, to be made wholesome and tolerable. When the other, whoever they may be, is unable to bear the pain of trauma alongside the victim, the shame is so much greater. Sexuality is so closely linked to shame, because it is the emergence of an urge that seeks connection, intimacy and eventually intercourse. Shame is about the past, the worst that has already happened. It is a mistake to believe that someone acutely sensitive to shame is too fragile to bear any more; these are clients who have already survived. Shame inevitably arises in the therapeutic relationship, and needs to, in order to be borne relationally. 'For individuals experiencing intense shame, no words can capture the assaultive intensity of the experience. It is only through *reliving* the trauma through enactment with the analyst that its magnitude can be known by an "other" ' (Bromberg [1998] 2001: 296, original italics).

The way society – the wider field – deals with the unbearableness of trauma creates a precondition for shame. A number of factors come into play in this respect. First there is a palpable sense of shock when traumas are publicized, whether natural disasters, man-made or individual. Shock is a defining characteristic of trauma and this is held in the field. It is not uncommon for there to be a collectively held denial about some kinds of atrocities that are carried out against other people because they are so far

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removed from our agreed standards of acceptable behaviour. A victim of domestic violence may feel ashamed for loving her partner when everyone around her is telling her that she should leave and move on. 'The shame of abuse is compounded by the ultimate shame of denial: nothing happened, you imagined it, your very reality and experience are not wanted or received in the field; relationally speaking, you don't exist at all' (Wheeler 1996: 225).

Collective shame and cultural norms

Such denial exists at different levels within the field: family, social groups, institutionally, and in legal process. Terr describes a situation in which doctors failed to examine for evidence of abuse in a group of nursery school children, and considers that this was a group-held response to shame: 'the physicians, in other words, may unconsciously have preferred not to look' (1990: 121). Wheeler also comments on societal shame related to trauma. He says: 'In a Gestalt field model, [the factors contributing to PTSD are part of] a field characterized and organized by deep internalized shame' (1996: 225), and this results in a tendency to pathologize the victim. Protection is often afforded more readily to perpetrators than to victims, in families and more widely; whistleblowers are vilified and scapegoated.

The more recent case of Jimmy Savile illustrates some of the powerful dynamics around abuse. He used his power to maintain his celebrity status while apparently abusing hundreds of young and vulnerable people, at the cost of them being taken seriously. His actions were writ large for all to see, yet the magician waved his wand and the entire nation fell asleep for forty years. On waking up, the collective sense of shame for the failure to protect has been tangible. Such dynamics are repeated in families and communities on a daily basis, across the world. In the face of shame, the offer of protection to victims is defensive rather than authentic.

Anonymity provided in law to victims of sexual violence while providing necessary protection also speaks to the shame of trauma and suggests that there is something to hide; this is reflected socially, in medicine and the media. Within the wider field there remains a split between 'undeserving' victims, the clean-living virgin who needs protection, and those who were 'asking for it' by virtue of their chosen lifestyle. Further, we live in a culture that endorses active humiliation as a means of control and oppression; 'naming and shaming' of those who stray from given standards of behaviour, even in our own psychotherapy profession, is in vogue. In this climate, it is challenging indeed to heal the wounds of trauma of which shame is a manifestation. There is stigma associated both with the feeling of being dirty and untouchable, and with the diagnosis of PTSD; it is a *disorder*. A campaign, initiated in the American military,

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seeks to reduce the stigma of the diagnosis and facilitate early access to therapy by changing the name to Post-Traumatic Stress *Injury* (http://www.posttraumaticstressinjury.org/letters-endorsing-the-change-from-ptsd-to-ptsi/). This would be more consistent with Gestalt psychotherapy values, and with the potential for healing at the heart of this book. Multiple factors echo the injunction to remain silent which is so often part of the experience of trauma. Trauma is a disowned, denied and alienating secret.

Working with shame

Much has been written in the Gestalt literature and elsewhere about how to work with shame; the general principles of a dialogic attitude apply no less to working with shame in trauma clients than to shame-prone clients in general. What is most needed in therapy for trauma clients is a restoration of their sense of humanity. In Gestalt theory there is no one polarity to shame. Wheeler suggests luck (1996: 49), Yontef suggests pride (1993: 493), and Lee proposes support (1996: 10) as polarities of shame. The two latter concepts are more relational than the first. It is helpful to consider another polarity in relation to trauma victims: that of acceptance. This term has some subtlety in this context. It implies both relational and self-acceptance, a coming to terms with who one really is, and a repair of the alienation of dissociation. Acceptance requires integration of body awareness and honouring of instinctive survival defences. It also includes acceptance of the past, a stage of grief equivalent to the third stage of Kepner's Healing Tasks Model – undoing, redoing and mourning. Finally, it is consistent with the Paradoxical Theory of Change (Beisser 1970).

It takes time, a long time, to heal the wounds of shame. Acceptance comes only by incremental stages. The development of an attitude of compassion for the wounded traumatized self (or selves) is crucial for recovery.

Experiment

Make a note of where your attention is, and of your physical and emotional state as you begin this exercise. Now, spend some minutes visualizing an image, colour or memory that elicits feeling friendly towards yourself. Take it in and notice where it goes, how you receive it. Stay with this feeling for as long as you find helpful. Now try sending this image, colour or memory to someone else, perhaps someone who has hurt you, or to a client.

(Adapted from Davis and Hayes 2011: 202)

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There are countless exercises of similar type, often drawn from Buddhist practice, which clients find as a soothing and healing counterpoint to their sense of unworthiness. Another example is the practice of Loving Kindness, or Metta (see Brach 2003; Faye 2007), a form of meditative mantra which clients can adapt to their individual needs and desires. A basic form of Loving Kindness is as follows:

> May I accept myself just as I am.
> May I touch great and natural peace.
> May I know the joy of being alive.
> May I be free from suffering.
> (adapted from Faye 2007: 50; and Brach 2003: 297)

For some clients the issue of forgiveness is a significant complication. Forgiveness has many meanings for different people. Harris defines three possibilities: seeking forgiveness for wrongdoing, forgiveness of those who have caused hurt, and forgiveness of self (2007: 114). A focus on the last two is most pertinent to trauma work. Harris considers that forgiveness is 'a choice about how one deals with the present experience of past betrayals' (p. 107). It is a way of completing unfinished business, but it is unlikely to be a choice that can be made without first fully understanding one's pain, in the spirit of the Paradoxical Theory of Change. Forgiveness is in one's own self-interests, by virtue of 'letting go of one's hurt, bitterness, and anger, which prevents the hurtful act from controlling one's life' (p. 109). He cites a number of research studies which demonstrate improvements in health and well-being which result from forgiveness. Forgiveness in these terms does not mean denial or apportioning of blame; it means acceptance.

A sense of gratitude can be developed, to come alongside more difficult feelings associated with trauma (Harris 2007: 118), and this should include gratitude for the ways in which one has survived. A sense of gratitude can help to provide a polarity to the notion of a hostile world and an unbearable existence. It counters shame by offering a sense of worthiness, that there are good things to be experienced. Gratitude may be related to resources, in the natural world for example, or for bodily experiences that are healthy, comfortable and appropriate. This notion may be introduced quite lightly early in the therapy, held as an attitudinal stance by the therapist in the hope that the client will mirror this in the course of time.

Both compassion and forgiveness require an attitude of care for the self, a determination to attend to safety and soothing, to put into reverse the attacking nature of shame. Sapriel cautions however, that for trauma clients care of the self may represent a loss of the other (2012: 115). For

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clients who have suffered trauma after infancy, it may be possible to reclaim a sense of a time when they did like themselves better, did not feel so shame-full. Developing resources representing previous competence, mastery, pride and confidence can be pivotal in therapy, bringing a realization that shame is not all that the client is or can be. It is also helpful to attend to the qualities that the client feels they need to overcome their trauma, and if they cannot find them in their own history, they can be encouraged to think of someone they know, or know of, who holds these qualities – a role model as a resource. If they can find other ways in which they identify with their role model, so much the better.

Therapists need to be alert to the risks associated with self-harm, first and foremost by demonstrating the care, compassion and acceptance that are missing in the field. It is important to develop a shared understanding of the phenomenology of self-harm and what precedes harming episodes, so as to recognize and accept the likely regulatory function it serves. There can then be agreement that the aim of therapy is not to stop self-harming, but to develop alternative ways of finding soothing. Lastly, therapists need to be vigilant about the risks of self-harm following therapy sessions, and take great care to prevent such dysregulation within the session that the client resorts to cutting, bingeing, picking a fight, or substance abuse afterwards.

There is a place for psychoeducation about trauma in order to reduce the impact of shame. Explanations and knowledge normalize experiences which feel marginalizing or incomprehensible and therefore shameful. Appropriate interventions may range from making clear and simple statements like 'What he did to you was a crime', 'That was a disgusting thing to do to you . . .', to explaining the role of immobilized defences and demonstrating respect for creative adjustments. Finding commonalities with other victims limits the sense of being unacceptably different, and when group therapy is not an option, comments like 'Some people find that . . .' are helpful. However, pacing of such interventions is essential since trauma clients may be unready to hear them initially. In preparation the fixed gestalts which maintain shame, processes need to be loosened over time. In these ways it is possible for clients to grow into an attitude of acceptance, encompassing embodied self, other, past and present.

Case Study Part 4

The more Eve struggled with feeling and expressing her anger the more she continued to treat herself as an object of contempt. She felt a great

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deal of disgust for her body, especially since 'it' had done nothing to get her out of the terrifying situation of captivity in which she was raped. Eve saw herself as weak and useless, and felt that the trauma and this perspective on herself defined her. She felt permanently damaged. Her shame was greatly compounded on those occasions when Eve deliberately injured her genitals to regulate her pain. A momentary relief was quickly followed by guilt and greater self-loathing, and a fear of discovery. She expected me to react with horror and disgust, rather than compassion when she disclosed this self-harm to me. It was a very long time into therapy before she could stay in a conversation about self-harm with me.

It helped a great deal that I chose to explore instances of Eve's self-harm phenomenologically. Together we made sense of the distress that she was in and the relief she felt, however fleeting. It was important too that we could understand that even though she was in some ways inflicting the same violence on herself as her abusers did, she was now in a degree of control. This provided us with another opportunity to work with making choices that felt better, even where Eve found choices that challenged her shame in sometimes uncomfortable ways.

The position I took in respect of some of the hardest aspects of Eve's current and historical field was consistent and gave her a bridge to a less terrifying world. I genuinely felt warm and compassionate towards Eve, and repeatedly asked her for the kindest things she could tell herself and looked for ways of encouraging her to increase her self-care. My biggest concern, though, was the lack of care she took of herself in relation to others. Out of compensatory guilt, Eve was letting Freya run rings around her, and Eve was afraid that if she said 'No' Freya would be harmed. Eve had protected herself during her attack by not protesting. Her work with the mentally unwell was another echo of how she had pacified her deranged attackers in Kosovo. Eve was over-extending herself in an attempt to make things better.

As we looked at the processes and beliefs that kept Eve in this difficult position and she learnt more about trauma she came to recognize for herself the part that she played in her current relationships. Eve developed an awareness of the choices available to her, even where it was difficult to act on them. Her relationship to her trauma changed when she could begin to be sad for the pain she felt, rather than attacking it in the belief that she should be different. She understood more about the defensive role she had taken during her ordeal and this helped her to feel better about herself.

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Summary

Shame is an emotion that everyone is familiar with, regulating our interactions with the environment to keep personal identity, dignity and integrity intact. Somewhat different from other responses to trauma, shame is experienced as an attack on the self of the victim and therefore deeply personal, rather than an attack on the physical body. The experience of pervasive shame affects profoundly the way clients perceive themselves and others, and their capacity for full engagement at the contact boundary. These are clients who have difficulty accepting themselves for who they are, and as in trauma responses, do not update information about the current field easily. Shame tends to loop back on itself, clients feeling shame for being ashamed, shame heaped upon shame. It therefore has a role in maintaining the cyclical reliving of trauma which defines PTSD. Although shame is a broader problem than that of trauma, the two are inextricably linked.

Shame is present in the primary features of fear, helplessness and disconnection which were the subjects of foregoing chapters. Coupled with states of high autonomic arousal, avoidance and intrusion is shame, which can be triggered by any of these trauma-related experiences. When shame or humiliation has been an explicit feature of the original trauma, shame is also a trigger in itself. Helplessness is a precursor to shame, because it places power in the wider field and relates specifically to immobilized survival defences. Shame feels so interminable as to give rise to hopelessness and resignation. It is a profoundly alienating experience, disconnecting the individual from a world in which they feel shunned or unwelcome. The intense bodily involvement in shame is such that it may be denied or dissociated, and in addition dissociative parts may hold shame or be felt as shaming.

Shame-laden attacks on the self often indicate a shift in the locus of control, victims taking more blame for the situation than is reasonable or necessary. It is a process that is related to ruptures in attachment bonds and this applies specifically to the configuration of the victim's relationship to perpetrators in the case of personal attack or abuse. In this process, blame becomes polarized in the dynamic between the victim and the perpetrator. Gestalt therapy understands relationships to be co-created, neither party taking full responsibility, but correspondingly, neither party necessarily taking an equal share. By this token, we come to understand that trauma victims have a small degree of responsibility for the events which have overtaken

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their lives, if only in so far as their reactions are theirs and theirs alone. It is phenomenologically consistent to allow victims to accept this minor role in the evolution of their story, more proportionate to the event and allowing some sense of control.

When terrible things happen to people's bodies, they may feel themselves to be disgusting, dirty or contaminated. Embodied life and its vital needs become shameful and may be disowned or denied. Body shame leads often to an inability to take appropriate care of oneself, and victims may ultimately resort to self-harm. This is often a response to terrible pain, regulating the arousal that cannot be contained. Acts of self-harm or mutilation make visible, and therefore manageable, that which cannot otherwise be tolerated. Risks of self-harm of one sort or another increase after therapy sessions when there is inadequate containment and regulation within the session. Shame is understood as a state of dysregulated arousal, associated with prevention of relational rupture. Different physiological defences come into play in shame processes, linked biologically to the networks and systems that deal with fundamental emotions of fear and threat.

The way society or the wider field deals with traumatic events is not dissimilar to the way individuals respond to them. Shock, disgust and fear arise along with denial, disbelief and dissociation. The reality of some victims' experience is so intolerable that it cannot be borne by others in their immediate world. Such reactions only serve to compound the shame and secrecy that surrounds much trauma, and the stigma of being treated for a medicalized 'disorder' makes matters worse. It has been suggested that such factors reflect a shame-laden society.

Acceptance is proposed as a polarity for shame in work with trauma victims. While much of therapeutic work with shame is the same for trauma clients as for others, there are a few specific considerations for this client group. Developing compassion over time for one's considerable wounds is seen as a key to healing, and links to aspects of Buddhist practice and non-violence which are acceptable to clients can be made. Forgiveness is a way of letting go of the emotional ties to the past that are caught up in resentment and pain. The development of resources related to confidence and achievement is to be encouraged, along with a growing sense of gratitude and appreciation for survival and aliveness.

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PART 3
A relational home for trauma

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10 The role of the therapist

The way the therapist approaches the work plays an enormous part in the healing process, a different embodied relational ground from which the client can safely recover. According to the Integrated Model of Change outlined in Chapter 2, the role of the therapist is not completely consistent with Beisser's ideas about the therapist as change agent. In working with trauma victims the therapist has the clear intention to effect change in those moments when the client cannot support this themself. How the therapist creates the conditions for change is the focus of this chapter and one of the keys is to consider safety. The power the therapist holds and transference issues are explored from the perspective of trauma work. The relevance of the social engagement system and Porges' Polyvagal theory is described. The structure is that used in Part 1 of this volume, providing some theoretical ground for the work.

The therapist and change

In Chapter 2 we discussed the Paradoxical Theory of Change (Beisser 1970) which exhorts Gestalt therapists to decline the role of change agent. In working with clients who have been traumatized this is an ideal and somewhat naive position, as posited by Philippson (2005). He goes on to claim that there are situations in which the therapist needs to be a change agent (2009: 136), as the neurological deficits of trauma require. The Paradoxical Theory of Change rests on the assumption that the client can take responsibility for their own process and has the relational skills to support this. This is far from the case in traumatized clients because of their neurobiology, relational history and creative adjustments. A corollary of the theory is that the therapist relinquishes the expert position in the interests of equalization of power. What trauma work points towards therefore is something subtle: that the therapist takes responsibility to the

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degree that the client is unable to do so, a co-creation of support in the relational field. Neither is this a fixed position but one that will vary moment by moment, and be adjusted according to the ongoing phenomenological process of the client. The goal, for we must have one, is to establish a more horizontal position over time, in line with the Integrated Model of Change proposed in Chapter 2.

Beisser's injunction against the expert therapist who knows what's best for their client needs to be examined in the light of the experience of trauma clients. Beisser's caution is principally against taking an objectifying position in which something is done by one person unto another and 'Hey presto! You'll be fixed'. It is obvious to see how this might replicate relational trauma for our clients. However, Hycner observes that an objectifying position is necessary at times in order to accomplish certain goals (1993: 7). In order to achieve the goal of reasonably reliable stability within the window of tolerance, the therapist must apply a blend of both science and art – the specialized knowledge supplied by neuroscience *and* the skill to apply it in a relational manner. It is these qualities of knowledge and skill that are the hallmark of the true expert.

Furthermore, it is helpful for therapists who deal with trauma to have a working understanding of human anatomy and physiology (see Juhan 2003; Stauffer 2010), and some knowledge about complementary bodywork approaches in order to direct clients to a wider support network. It is important to understand that this is not to be treated as the privileged knowledge of an expert, but something that can be shared with clients who often find it helpful to have an explanation of how they came to be in this degree of distress. Teaching clients about trauma and psychoeducation, offered appropriately and collaboratively, helps to normalize the experience of traumatic intrusions and numbing and clears some confusion. It also offers choices: 'To teach is to show a person that something is possible' (Perls 1969: 36). Having said all this, the ability to meet each client with the freshness of a beginner's mind stands as an abiding principle of Gestalt therapy. The phenomenological approach requires that we have the humility to un-learn what we already know and re-learn what is unknown. Those clients who demand this of us are a gift. Despite the fact that there are new ways of conceptualizing our work with trauma clients and more effective ways of addressing their needs, there remains as much uncertainty – and therefore opportunity – in this work as in any general psychotherapy.

Power and horizontalism

The beginner's mind opens up the possibility that the therapist will in turn be changed by the client, as Beisser suggested. In the case of trauma this

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means to allow ourselves to be changed as human beings by highly dysregulated and disorganized clients whose impact we might more intuitively resist. In this rather ambiguous situation, the potential for a more horizontal relationship still exists, the ideal set by Beisser. The notion of creative indifference (Friedlander 1918) underpins the concept of the horizontal therapeutic relationship: 'By remaining alert in the center, we can acquire a creative ability of seeing both sides of an occurrence and [of] completing an incomplete half. By avoiding a one-sided outlook, we gain a much deeper insight to the structure and function of the organism' (Perls 1969: 14–15). In the case of trauma clients, we only see one side of an occurrence if we remain centred in the classic thinking of the Paradoxical Theory of Change, and ignore the potential of the client locked in their neurobiology, the goals that must be achieved in the work and the means for achieving them. These clients require their therapists to invest themselves more fully in the work before horizontalism can emerge.

When the locus of control shift (Chapter 7) has reorganized the boundaries around power, trauma victims do not expect to find anything resembling a horizontal relationship. The client assumes a position of relational helplessness, and power dynamics tend to become severely and habitually skewed. Those who have creatively adjusted by becoming controlling and manipulative are not exerting real power in relationship but employ a more coercive and sometimes bullying style of relating, qualitatively different from authentic power because it is the polarity of their powerlessness. After all, while 'power' is a hot issue for many trauma clients, it is something that can be used for good or for ill: power may oppress, abuse and destroy on the one hand, and on the other facilitate and heal. We need to recognize that initially clients may have virtually no real sense of power while the therapist holds much, and that this balance must shift over time.

This imbalance is an example of how the therapist holds the tension between horizontalization and the power. The extent to which therapists can help to liberate their clients from the bonds of their past puts them in a very powerful position indeed; it is helpful to think in terms of the therapist's potency rather than dominance in this regard. Alongside this is a comment by Loewenstein and Goodwin: 'It is important to point out to the patient that the clinician, far from being in full control, is far more likely to be reactive to the patient's style of communication and statement of problems' (1999: 80). The degree of control exercised by the therapist may be reassuring or it may be threatening; either is grist for the mill.

The therapist does not have to decide how the client should live their life or what sort of person they are, but tries to restore self-functions. Therapists can be in too much of a hurry to try and hand over power to their clients, sometimes as a co-transferential resonance with their clients' lack of personal power. A therapeutic stance is one in which we hold that

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we act in the service of the other's recovery, while maintaining an attitude of creative indifference. The power we can creatively hold does not include coercion or pressure to change. The experimental attitude of Gestalt therapy is a great asset in this enterprise of working to shift power dynamics from the therapist-directed to the self-initiated: 'try this and see what happens' (Grigsby and Osuch 2007: 71). Levin and Levine (2012: 6) highlight the difference between change as by expert practitioner or by learning how to cure yourself with help or direction from a therapist. In trauma work we need a blend of the two with an increasing emphasis on the latter. One quality of the beginner's mind in the therapist is that of curiosity, an essential therapeutic tool in maintaining a respectful orientation towards the client's process, through which we can truly learn to meet.

Establishing the relationship

Harman suggests that 'The Gestalt therapist must be willing to ask, tease, cajole, provoke or demand contact from patients' (1982: 46). Such a proposition is too provocative for most clients who have a fragile process, including those who come with trauma in their field, but the spirit of this statement does encapsulate an important principle. Trauma clients are among those who find any kind of contact – with themselves, with others and with current reality – the hardest. The trauma therapist in the more evocative and dialogic manner of contemporary relational Gestalt must nevertheless insist again and again 'Don't go there, find your feet in this room now, come back to me'. The paradoxical tension inherent in this is something we simply have to live with.

The therapist's orientation towards health is likely to be at odds with the client's embodied orientation towards danger and threat. This influences the ways in which we are able to meet our clients. We can only meet our clients where they can be met, and in the case of trauma clients our meeting must include recognition of their neurobiological condition and the limitations this creates for us. Often the most genuine and humane meeting available is to invest fully and intentionally in bringing about a moment of relief in which a more regulated state and relational contact become possible. This is a meeting of a need, a relational validation of the client's dilemma, for the client needs first and foremost to be shown the way back.

It is bound to be difficult to make any relationship with someone who is beset by phobias of therapy and of the therapist, who has difficulty staying in the present or whose relational history includes betrayal, criticism or misattunement. For these clients a working alliance needs to be built around safety issues, emotional regulation, the relief of symptoms

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and the building of self-functions or resources, very much in keeping with the first two stages of Kepner's model. Some clients find that the possibility of relationship with a therapist is so fraught that it is most helpful to be given clear and structured instructions about what to do and how to develop the skills they need. For the therapist, it can feel for a time as though they are offering little more than the personalized contents of a self-help book. However, handled as dialogically as possible, the client will come to recognize that it was you, the therapist, who offered these helpful tools, and thus the seeds of a relationship are planted.

Bromberg asks a pertinent question: how is the work of therapy to be negotiated with patients for whom negotiation is an art that has never been learnt (2001: 137)? There is a particular implicit negotiated process with the client's state of arousal and capacity to be present which is at the heart of good trauma therapy. A simple and effective negotiation tool from Sensorimotor Therapy is to enquire over and again, 'Do you feel better or worse or no different when you try this [experiment]?' By considering this question the client learns to begin to reflect on and discriminate their experience, to make choices and to ask for more of what they need. This question also has the effect of overriding habitual cognitive responses by going straight to the felt sense. Supplementary questions may include phenomenological exploration of *how* the client can tell if it's better or worse, and the specific physical components of their reported moment by moment experience, the awareness continuum. It is a task of trauma therapy for the therapist to provide the optimal conditions for change, most often a case of 'grappling' together with where to go and how to get there (Boston Change Process Study Group 2010: 101).

The Polyvagal theory and social engagement

The idea that we are hard wired for contact has been prevalent in relational Gestalt thinking for a long time, introduced as a metaphor by Lynne Jacobs in about 1987 (personal communication, 2012). Neuroscience research has since confirmed the existence of such a system and the workings of it. One theory, part science and part concept, is the Polyvagal theory developed by Stephen Porges in 1997. Polyvagal theory refers to the function of the vagus nerve. This is the tenth cranial nerve, whose fibres originate in the brainstem; it is the only nerve to derive from this deep emotional brain. It is also one of the longest nerves in the human body, the word vagus having a Latin root, meaning 'wandering'. The vagus nerve has branches serving the head, face, throat, lungs, heart and stomach, and has a key regulatory action on these organs (Stauffer 2010: 51). This makes the vagus nerve essential for our survival (Stauffer 2010: 46).

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The Polyvagal theory elegantly makes clear the relationship between the brain and the body, and proposes a *bidirectional* communication between them. This is a theory of integration rather than dichotomy, and therefore of interest in relation to trauma therapy. You may sometimes notice a client's stomach rumble in connection to an emotional shift – that is usually caused by the vagus nerve mediating arousal. Similarly, communication between the brainstem and the heart via the vagus nerve regulates blood pressure and therefore how relaxed we may feel (Stauffer 2010: 160). It is these links with states of arousal that are most pertinent to trauma work.

The regulatory function of the vagus nerve is associated with the ANS, which we know to be hugely important in managing states of safety and danger. Indeed, primary emotions are survival based and must therefore be *integrated into cardio-pulmonary regulation* (www.trauma-pages.com). The Polyvagal theory proposes three distinct neurophysiological systems:

(1) cranial nerves to regulate the face and to mediate calm autonomic and behavioral states;
(2) sympathetic-adrenal system to increase metabolic output; and
(3) an inhibitory vagal system to decrease metabolic output and promote freezing.

(Porges 2009: 39)

Porges has conceptualized each of these systems as being connected to the layers of the Triune Brain (see Chapter 2), and uses the metaphor of traffic lights to illustrate this. The green light indicates being in a safe environment, where we can engage socially, think, understand and play; this is attributed to the cortex. The amber light indicates the perception of danger which will not threaten our life, so we can mobilize and attend to the signs of danger, but means that we are unable to connect well or to hear clearly; this is related to the limbic system. Third, the red light represents an immobilized state in the face of life threat, in which we shut down protective reflexes and feign death; this is associated with the brainstem (www.trauma-pages.com). Via a process Porges calls neuroception, we are able to distinguish sensory cues from the viscera as well as from the environment to help us to determine safety, threat and danger (2009: 45).

The impact on our ability to connect with others is clear in this model; Porges calls this the 'social engagement' system. The need for attachment and the proximity of others in establishing safety is an instinctive survival defence (see Chapter 6). Imagine for a moment that you are having a conversation with someone who suddenly turns away from you. How do

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you feel? Now imagine two people gazing closely at one another, and notice again how you feel. If we focus on the route of the vagus nerve via the muscles of the ears, eyes, face and larynx we can begin to get a clearer picture of the significance of this nerve in social interactions. The vagus nerve therefore has a key part to play in contact functions. We feel better when we seek eye contact, when we smile or speak gently. Important to note is the fact that we feel better when other people make eye contact with us, smile or speak gently because it is by these means that we communicate safety.

Mediated by the vagus nerve is the slowing down of the heart rate and regulation of respiration that is associated with safe and calm states. Kepner (workshop, Belfast, 2011) described how taking something in from another person is keyed into this physiological process, the roots of which are in suckling in infancy. Thus the impact the therapist can have on the emotional and autonomic arousal of the client can be either regulatory or not. Van der Kolk and McFarlane describe the case of a man whose wife had died while looking into his eyes and who could only recover when he took the risk of looking into the eyes of his female therapist who could tolerate his grief ([1996] 2007: 18). This level of connection, primarily through gaze, also triggers a release of the hormone oxytocin, which is associated with bonding between mothers and infants and with a sense of well-being.

Transference issues

Among other things, the shift in contemporary relational psychotherapies places more emphasis on relationship than on transference. However, issues of co-transference in trauma work are often compelling and call for attention. For both sides of the therapeutic dyad, the other has the potential to evoke uncontainable reactions. The client brings their fear, helplessness, disconnection and shame to the heart of the relationship; those organizing principles that risk being re-enacted when there are insufficient alternatives in place. Clients' orientation towards these dynamics is a gravitational pull that the therapist must find a way to counter. Tracking shifts in the client's experience can be demanding because at one moment the therapist represents safety, validation and even rescue – the resolution of deep yearnings for connection – and in the next moment the therapist may be seen as a controlling abuser. We enquire into the client's process and are perceived as intrusive, we hold back and are neglectful. The client's shifts may represent dissociated parts which may be malevolent towards the therapist. In such instances '[i]t is not generally useful to encourage a transference reaction to reach full affective force' (Perlman

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and Saakvitne 1995: 20). The client is not yet able to tolerate such feelings, and the therapist may need to be active in guiding the client away from them for the time being.

The therapist in turn can very easily get caught in these splits as they emerge; it happens in the blink of an eye. Trauma can be contagious: there is a strong possibility that the therapist will feel disturbed in some way as they enter the painful and fragmented world of their client. The ideas the client has about the therapist can have a rather paranoid feel to them. 'We are asked to feel threatened, devalued, objectified, ignored, and hated – on the other hand we may be idealised and revered, and required to maintain a standard of perfection that splits off any disconfirming aspect of ourselves' (Davis and Frawley, cited in Perlman and Saakvitne 1995: 24). What then, of the self of the therapist, which is brought into this heady and complicated mix of relational factors?

Experiment Part 1

The following exercise, comprising a series of questions for self-reflection, is presented in three parts. The questions provide a structure for you to reflect on the impact of working with traumatized clients and how you may respond to them. They also touch on aspects of your personal history which may shape your ability to be present to your client's trauma. If they feel powerful that is intentional, in order to increase awareness of your need for resilience and the role of personal therapy and supervision, among other things, that will support you in this work. These reflections lay the ground for the material in the next chapter. **If your answers to any of the questions in this chapter cause you unexpected distress or disturb you greatly, please take care of yourself and find immediate help. In addition, you may find the next chapter helpful.** You are encouraged to take your time writing your responses to the following questions. Be as honest with yourself as you are able; you do not have to share this writing with any one unless you choose to do so.

- How do you typically defend yourself in the face of verbal attack?
- What is your response to someone who becomes helpless and assumes the victim position? What of your persecutory or rescuer parts?
- How do you manage your need for contact when your client is disconnected and dissociated?
- How do you process idealization? What does it evoke for you?

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The co-regulatory approach to trauma therapy that is being proposed here does much to mitigate against the effects of vicarious traumatization. Extraordinary as it may seem, the work can be enjoyable, and this will be considered further in Chapter 11. There is inevitably a major impact on transference by working in such a way. Our aim is to provide a regulating environment, within which the therapist maintains a degree of neutrality that may nevertheless be perceived otherwise. When we actively resist dysregulating material, when we take a respectful and compassionate position in relation to the immediate relief of suffering and emphasize positive resources, we are more likely to evoke a positive transference, even though it is not our intention to do so. Philippson cautions: 'If the relationship is an attempt to create change by mimicking some idealised parental relationship, it is less effective than if a real intimacy develops organically (and with great difficulty at first) between therapist and client' (2005: 16).

It is this issue of the trauma therapist's intention that is crucial to working with transference. It needs to be the therapist's active intention *not* to replicate relational dynamics that have been detrimental in the client's history. Such replication is most likely to occur if we allow a negative transference to develop, though it must be stressed that we cannot at all times avoid this. This is a situation that becomes unworkable, in which the client cannot engage fruitfully in the process, and may be revictimized. It is far less risky to run with an engaged positive transference, in which the relational dynamics become grist for further exploration when the client can tolerate relational process. On this point Turner et al. comment that 'It is important for therapists to accept the fact that this need for idealisation is not founded on their real, attributes (which in their anxiety to stay in control, patients barely perceive), and that patients idealise them in order to replace the sources of security that were destroyed by the trauma' ([1996] 2007: 553).

Therapist as (re)organizer

In Part 2 of this book, we explored the various ways in which traumatized people reorganize their experience and their field, especially relational boundaries. Trauma is first and foremost a neurobiologically based regulator of boundaries within the entire field. Trauma therapy offers clients the opportunity to understand their creative adjustments and to reorganize their experiential ground, principally somatically. Earlier, Chapter 3 focused on the ways in which the ground of trauma becomes sedimented and the figures arising from it rigidify. The therapist offers new ways of structuring the ground both functionally, through experiments and

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resourcing, and relationally. The embodied presence of the therapist is an invaluable tool in this enterprise. Delisle observes that 'the therapeutic relationship, before it can be a reparative space, must be a space for reconstruction' (2011: 65). There is an important relational component in directly engaging to loosen fixed gestalts, whereby 'The therapist is pulling both parties out of the pattern' (Philippson 2012: 89).

One of the key tasks the therapist undertakes is to actively intervene when the client moves out of their window of tolerance. The clues that such intervention is necessary may be sensed via some change in the client, or through the therapist's awareness of their own embodied state, or both. Sensorimotor trauma therapy (Ogden et al. 2006) asks clients to drop the story as soon as signs of dysregulated arousal emerge, to 'park it somewhere else', and to find a resource in the present moment that feels better. These may be resources that have been created together in the past and can be relied on, or they may be developed organically in the moment. All trauma therapists need to develop the confidence to check regularly on how the client is feeling as they recount some detail from their life; we must hone the skill of interrupting, even insisting that the client direct attention to something more regulating. This supports the client not only in their reorientation towards more resourced states, it opens up choices and reorganizes the relational field. The therapist's refusal to go to those places for which support is lacking models containment and clear boundaries.

Experiment Part 2

- How do you tend to manage your own experience; what principles guide you?
- What personal history do you share with your client? How do you regulate yourself around this?
- What are your own experiences of love, hate, aggression, longing, sexuality, grief and terror?
- What is your relationship to your own body and your body image?
- What are your feelings towards those who hurt others, especially children?
- What is your relationship to your potency and authority as a therapist; how do you hold them?
- How do your gender, race, religion and other cultural factors bias your responses?
- What differences do your therapeutic experience, training and theory make?

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The therapist not only needs to embody missing polarities and self-functions, they need to model them. This is another key way in which the therapist plays a part in reorganizing the ground. This requires that the self of the therapist has enough resources to contain strong emotions, to remain grounded and in touch with their embodied senses moment by moment, to reflect on experience, to have curiosity and to demonstrate clear boundaries. The therapist's body becomes a mirror and representation of something that needs to be owned.

One important attitude that the therapist can model is the capacity to tolerate uncertainty. On the other hand, offering a 'menu' of possibilities helps the client to be able to determine and own what fits for them. For example, one client used only the word 'nice' to describe anything that wasn't unpleasant. It helped her to expand her vocabulary when I asked if she meant 'pleasant, lovely, comforting, delightful, kind or something else? What is the most accurate word for you right now?' This kind of exploration places more emphasis on the missing polarity and keeps the client in the dialogue. It invites the differentiation of experience that is compromised by trauma. Important also is work with the disowned self-states or parts that become split off after trauma. By naming the issue and encouraging the client to develop inner dialogues and co-consciousness, the therapist becomes a model of relating from a more integrated state.

The therapist and emotional regulation

The therapist's attunement to and interest in the client's state of arousal is a relational dynamic that the client may never have encountered before. Therapist and client learn to collaborate around arousal, as the client becomes increasingly interested in and trusting in the process. There are times in trauma work that the therapist needs to build successful exchanges around less charged material or the therapist will lose footing and the client be lost. At other times the material is too hot for the client to tolerate and it is the therapist's responsibility to de-escalate the situation as quickly as possible. As was discussed in Chapter 4, the client who moves outside of their window of tolerance needs help to return to it, because they are beyond the threshold of organismic self-regulation. For example, when a client becomes triggered into a state that removes them from present contact, the switch can happen extremely fast and it is not helpful to try to explore what is going on for the client; it may even be extremely unhelpful to do so. The therapist needs to switch equally rapidly into a mode of taking more charge, knowing what to do or at least what might help. Cozolino tells us that biological processes need to be reversed as soon as possible after being triggered to allow the body to do the job of recovery and repair (2002: 252).

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There is an ethic that needs to be borne in mind, concerning the potential risks to clients of remaining dysregulated and out of contact. It is a different mode of therapy, requiring flexibility on the part of the therapist and a wide range of skills. However, this is more than simply a management issue; the therapeutic value is in helping clients to distance themselves from emotionally uncontainable experiences without dissociating (Fisher 2001). This is a self-function that we need to support actively. One client found this process of 'shepherding' (her word) her away from the story helpful, because she didn't have to grapple with it in a way that made her anxious. My client's lovely and accurate term evokes a comment by Hycner and Jacobs about the therapist as a steward of the dialogue (1995: 13); *the trauma therapist needs in addition to be a steward of arousal.*

Experiment Part 3

- What is your response to difficult intense emotions? What is your experience of working with them or of resolving them? Try and think of concrete examples and write about what happened.
- What response do you have to hearing stories of appalling abuse, torture and suffering? Shock, denial, shame, anger, blame, or dissociation may be among them.
- What of your own need to be comforted or regulated by your client?
- How do you support yourself both in the moment and in life generally?
- What brings you a sense of calm?
- Name at least three people you can turn to for support.

The Window of Tolerance Model can be considered usefully from the perspective of the therapist (see Figure 10.1). As therapist you are neither creatively indifferent nor taking on the mantle of change agent all the time, but shuttling backwards and forwards between the two as the client's arousal levels change. You and your client both need to learn early on in the therapy what changes in arousal look and feel like; you will often pick this up on an embodied level, aware perhaps of a shift in energy in the room, or of a change in muscle tone or orientation in your client. Similarly, you both need to understand what specific interventions are most helpful for different degrees of dysregulation, for both hyper- and hypoarousal. This information is important in order to enable the ability to spot these changes almost before they happen, returning the client to the safe emergency within the window of tolerance as quickly as possible.

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	CLIENT	THERAPIST
HYPERAROUSAL	• Past focus, creative adjustment • Unavailable • Unsafe • Chaotic • Choiceless • Overfocused • Implicit memory • Confusion	• Aims for safety, 'glue' • Drop content, new frame • Establishing ground • Moderate to high risk • Narrow attention • Focus on sensation • Leading • Directive • Grounded • Present • Embodied • Slow, soothing
WINDOW OF TOLERANCE	• Focused • Narrative • Processing • Choiceful • Response-able • Flexible • Available for contact • Present-focus • Explicit memory • Meaning making	• Aim – exploration, loosening fixed gestalts, 'solvent' • Open attention • Low to moderate risk – the 'safe emergency' • Process focus • Sharpening figure • Creatively indifferent • Following • Phenomenological tracking • Receptive • Curiosity • Experimental
HYPOAROUSAL	• Unfocused • Choiceless • Rigid • Disconnected • Unavailable • Past focus, creative adjustment • Implicit memory • Confusion	• Aim – presence, small drops of 'solvent' • Narrow attention • Moderate to high risk • Focus on mobilization • Establishing ground • Leading • Directive • Still, encouragement, adding some energy • Drop content, new 'frame'

Figure 10.1 The therapist's role in regulation

The expansion of the window of tolerance happens in incremental stages, therapist and client learning together the steps of the dance needed to re-establish the safety needed. The client's confidence in the process and in your reliability as a regulator is thereby increased, important stages en route to increased sense of self-regulation.

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The therapist takes over control only for as long as is needed, staying present as much as possible. For example, they can remind the client that they are in touch with a memory, something that has passed, and ask them to put it to one side for now and focus on their breathing, or something safe in the room. Choices can be offered within the dialogue, such as, 'Is it more helpful or less to be doing this?', and later, 'would you like to tell me what happened or would you prefer to let things settle some more?' These enquiries help bring into the verbal and explicit domain the previously unverbalized implicit material, allowing reorganization and integration.

A degree of guesswork is needed on the part of the therapist when the client's story is not yet in the shared space between them, because the client's pull to have the story told is often an intense energy which needs to be resisted until they are able to be present to it. This is another important reason for working towards regulation as a key to recovery. The Boston Change Process Study Group consider that: 'The intentions of most interest to the psychoanalytic endeavour are those intentions to make and adjust the state of the relationship' (2010: 149).

Clinical vignette

Amy had been traumatized through her long history of medical treatment for a congenital bladder deformity. She had failed surgery which left her in pain, and over time she began to require sedation to enable doctors to carry out investigative tests. To make matters worse, on the last occasion the sedation she was given for the procedure failed to work and she was left with full conscious – and traumatic – memory of the entire process, and her shock and distress were misunderstood by the doctors. When Amy had increasing difficulties, she did not attend her routine hospital appointment. She delayed for several months, the avoidant behaviour of PTSD. When she became clearly unwell, Amy began to work more actively on the problem in therapy. Her initial reaction was to get herself out of the situation once again, a defensive flight response, and she entered a highly dysregulated state which lasted over several weeks. Her terror of going through this investigation again was extreme, and I pointed out that she could not make a real choice at the moment because she was driven entirely by fear.

I negotiated with Amy to work together to increase her choices by helping her to regulate her severe trauma reactions, to re-establish her window of tolerance which she had lost touch with, and to develop some new resources specific to this situation. This was the territory we inhabited time and again in the coming weeks. Because Amy seemed to have been taken over emotionally by a traumatized self-state, I also

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actively supported her stronger, less traumatized self to emerge and contribute to her more resourced state. Throughout this time I remained creatively indifferent about what decision she would eventually make, while at the same time working within a trauma-focused perspective in order to support the making of those choices.

Privately, though, I was concerned about Amy's illness, and hoped that she could reach a position in which she could access the help she needed without being re-traumatized by it. With more ability to stay in touch with a host of new resources, including the ability to regulate herself more reliably under stress, Amy went ahead with the investigation, the sedation was effective and the hospital staff kind and supportive. What astonished me was the fact that several weeks later, Amy told me in a quite matter of fact way that she had been for a routine smear test. This was again something she had avoided for many years because of its similarly triggering intrusive nature. This time she was able to handle the whole thing with a degree of equanimity, and without my support.

The therapist and the here-and-now

First and foremost the trauma therapist serves as an anchor to the present. The concept of dual awareness (Rothschild 2000) requires that the past trauma cannot safely be revisited unless the client has a foot in the present moment as well, in order to orient them to current reality. The presence of the therapist can be a powerful influence in ensuring that the client does not fully disappear into overwhelming terror of the past. One client in the processing phase of therapy engaged herself fully in some intense bodily reactions to traumatic material. She observed that it was only possible to do so because she knew that I was there actively supporting her physical process at the same time. This is a way also of helping the client to come back. There is a therapeutic skill in staying connected in the face of disconnection.

The therapist has a key part to play in holding the continuity of experience for the client. This can be achieved by making links that the client holds out of awareness, in recalling previous sessions and highlighting the fluidity of experience: now this, then that. Self-disclosure of embodied phenomenological process by the therapist is one way of bringing continuity of experience into the room and has a containing effect on clients. Bromberg cautions against using self-disclosure as a technique, but regards it nevertheless as a human act, particularly when the therapist is 'free of internal pressure (conscious or unconscious) to prove his honesty or trustworthiness' (2001: 261).

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'On another level, the therapist serves as an external neural circuit to aid in the integration of networks left unintegrated during development' (Cozolino 2002: 283): assuming that the therapist is able to maintain a reasonably regulated state, they will act as a kind of temporary cortex for the client, filling in for an as yet unavailable self-function, and communicating calm, curiosity, attentiveness and safety. Bromberg quotes Kahn: 'It is for the analyst operating as an auxiliary ego . . . to register dissociations and help the patient to integrate them' ([1998] 2001: 136). Here is a function of holding the other in mind, sorely needed by our more relationally traumatized clients. For the therapist the client is held as someone who continues to exist outside of immediate experience.

It is often assumed that the therapist needs to act as a witness to the trauma and to the suffering of the client. It is true that clients who have suffered much on their own need the reassurance and connection with a safe companion on their journey. However, the Window of Tolerance Model implies that *it is less important for the therapist to be the witness than it is for the client to be enabled to witness their experience for themself*. This is the function of healthy egotism that working in mindful awareness within the window of tolerance makes possible. Both therapist and client need to find a way of being participants and observers together.

> Therapists must be willing to allow themselves to be touched and moved by the patient . . . Being present also means being willing to be both power*ful* and power *less* . . . But ultimately the therapist is powerless to *change* the patient, and sometimes the pain of wanting to make the patient's life better but being powerless to do so is keenly felt. The therapist who is present brings this pain too to the meeting.
>
> (Woldt and Toman 2005: xix)

Vietnamese Buddhist monk Thich Nhat Hanh speaks of the gift of non-fear, which is perhaps the greatest gift therapists can offer their trauma clients; it cannot be achieved alone.

Summary

In revisiting the Paradoxical Theory of Change in Chapter 2, the different role of the therapist in trauma work comes to the fore. Beisser's claim that the therapist should not be an agent of change is challenged by the neurological condition of the client, who is less able to take their share of responsibility for the progress of therapy than others. The therapist takes a more active and directive role in the

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Integrated Change Model, but it is a somewhat more complex and subtle role that responds to the emerging stabilization of the client and accommodates to this, sometimes moment by moment. The key role for the therapist is to establish safety for the client, both in their external and internal worlds and in the between of the therapeutic relationship. Technical ways of managing this can help in the beginning to establish a relationship with people who may have few relational skills and tools. The Polyvagal theory of Stephen Porges is a way of understanding the brain-body links, especially in terms of responding to danger, autonomic arousal and making social connections.

There are inherent power issues in any therapy but in working with those clients for whom power dynamics have overwhelmed their natural sense of agency, the therapist intentionally takes a more powerful or potent position. Many trauma clients come into therapy with the expectation that trauma-related power dynamics will endure because they have become fixed in the locus of control shift. Therefore it is helpful to think in terms of a gradual transition of power from therapist towards a more horizontal position, the place at which Beisser's injunction can come into play along with other considerations of the Paradoxical Theory of Change. There is necessarily an impact on transference issues that emerges from this relational shift, one in which the likelihood of an idealized transference is increased. It is argued that this is preferable to the risk of the negative transference which can recreate the traumatic relationship.

By emphasizing the resources of the client the therapist contributes actively to reorganizing the ground from which the figure of trauma emerges. The therapist needs to be able to teach and model resources and integrative capacities, thereby transforming the implicit procedural learning of fixed gestalts into mindfully held explicit choices. In order to regulate arousal, when the client moves out of their window of tolerance a different set of therapeutic skills comes into play. The therapist must become more active in dropping attention to the figure that has caused the distress and supporting the polarity of safety. The here-and-now focus of the therapist supports the client to have a hold to some extent on current reality, in the service of being able to enter the traumatic past and process it within a widened and more resourced window of tolerance. The therapist holds together the discontinuous and fragmented threads of the client's experience with the aim of integrating a more coherent self-experience.

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11 The well-resourced therapist

This chapter entails a temporary change of key and a more personal voice: its subject is the selfhood of the therapist as one part of the therapeutic dyad. It begins with stories about the development and use of resources, particularly embodied ones from my own experience, and offers a range of experiments for you, the reader, to follow and develop for yourself. The examples that are presented are not to be taken as a template, but more as an illustration of one therapist's journey into more resourced embodiment; each therapist must venture on their own path.

The impact of trauma on the therapist is explored in the light of co-transference and vulnerability to vicarious traumatization, and the case is argued for an increase in the therapist's personal resources. The chapter goes on to consider the therapist as wounded healer and proposes that the work can be mutually healing. Exploration is also made of how embodied resources make a contribution to therapist presence and to the practice of **inclusion**. The neuroscience of mirror neurons supports the work and is given a twist in considering the impact the therapist can have on the client's mirror neuron system. Theoretically, the two strands of dialogue and embodiment are woven together to develop a theme of embodied intersubjectivity, akin to Kepner's concept of the Embodied Field (2003).

> Trauma therapy profoundly changes the therapist. We give up our familiar ways of being and beliefs about the world when we embark on this work with survivors of traumatic life events. These changes are both inspiring and disturbing, involving gains and losses. Rarely do therapists enter the field of trauma therapy with full understanding of the implications of their choice.
>
> (Perlman and Saakvitne 1995: 279)

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Personal story 1: gathering resources

I am not alone to have experienced a visit to Esalen as transformative. I went there in 2007 for a week-long conference; within a month I had resigned from my job and I could argue that this book is a consequence of that change, though there have been many different steps in between. What was it about Esalen that so profoundly affected me? Much of my answer is about the vision I received there. First, the content of the conference piqued my interest in neuroscience, opening up new and exciting ideas. Some personal feedback in a workshop importantly challenged and inspired me to risk stepping into a new place.

Second, the environment was profoundly soothing and nourishing. Situated on the dramatic Big Sur coastline of California, the landscape of Esalen is very much on the edge, and I found it took me to the edge of what I could become. I was fortunate indeed to have a room to myself, right on top of the cliffs, and with stunning views along the coast and out to the ocean. Even though it was February I slept next to a wide open window so as to be immersed in the sound of waves crashing on the rocks below me. That memory remains very vivid to me as though the waves continue to resound in my chest cavity. Third, I bought a book at the bookstore at Esalen which opened me up to a new embodied world.

That book is *Body and Earth* by Andrea Olsen. It is an experiential volume providing a 31-day programme for exploring the connections between bodily systems, perception and the natural environment, an ongoing journey I have continued one way or another since I returned home. The theoretical basis of the book was new to me, opening up explorations of experiential anatomy and leading me to the work of Bonnie Bainbridge-Cohen and Body-Mind Centering and other bodywork approaches. Through this work I developed an entirely new relationship to my own body, what Kepner would describe as deep embodiment (2003: 12). I found it enormously helpful to be able to understand a little about how my body works, to visualize what was going on inside me, and to experience an ever-increasing subtlety of embodied awareness. Chronically held arches in my feet released as I established a new relationship to the ground; my centre of gravity dropped about twelve inches from my upper chest into my belly; my shoulders fell about two inches, bringing my shoulder blades back and realigning my head so that my visual perception of and engagement with the world changed dramatically. All these structural changes happened over time as I worked with the new material.

Here is one of my favourite exercises from the book; whenever I do it I find it changes my perspective on my ego.

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The witness

Seated or standing in a comfortable position, eyes open:

- Choose something, living or other-than-living, on which you can focus your attention for several minutes: a tree, a pond, a chair. Find a comfortable position and allow yourself to witness, non-judgementally, for five minutes. If your mind wanders, bring it back to the process of conscious witnessing, observing whatever occurs.
- Pause in open attention. Now allow yourself to be witnessed by the 'thing' that you chose. Imagine that you are being witnessed by your tree, pond, or chair, non-judgementally, in whatever you are doing. 5 min.
- Pause in open attention. Write about your experience; read aloud to yourself or someone else. Witness as you listen. 10 min. (Olsen 2002: 60).
- I have added an element to this experiment for psychotherapists: imagine that you are sitting in front of a client in silence for five minutes, witnessing non-judgementally, observing whatever occurs.
- What is your embodied response?
- Now imagine that the roles reverse and the client observes you, witnessing non-judgementally, for five minutes.
- What do you notice in your body now?
- Write about this experience too; then read aloud to yourself.

Your responses to these observations may well have had something to do with mirror neurons.

Mirror neurons

The discovery of mirror neurons in monkeys and similar responses in humans has caused much interest and excitement, and yet there remains much to be learnt about these mechanisms. There is therefore a great deal of speculation and postulation as to the conclusions that can be drawn from the research. The discovery came about through research into the firing of brain cells in response to certain highly specific gestures and movements by other monkeys. Importantly, it was noted that when the subject monkey made the same movement itself, the same neurons fired, and hence the term 'mirror neurons' evolved (Cozolino 2002: 184).

Much learning of sensorimotor and other skills is thought to take place via the network of mirror neurons (Damasio 2000: 298): you first

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show a child how to tie a shoelace before they attempt over and again to do it themself; psychotherapy trainers demonstrate particular skills to their students. Siegel considers a specific property of mirror neurons to be their action potential, differentiating them from purely sensory neurons (2007: 350). The mirror neuron system is linked closely to perceptual and motor areas of the brain, forming a circuitry for 'resonance' (Siegel 2007: 350, 165).

Mirror neurons are thought to be responsible for enabling us to make representations of the intentions of others, to understand their state of mind. 'Mirror neurons demonstrate the profoundly social nature of our brains' (Siegel 2007: 166). These processes of perception and intention, mediated through the outer layers of the cortex become 'linked to . . . limbic/emotional processing and . . . alter[ ] limbic and *bodily states* to match those we are seeing in the other person' (Siegel 2007: 167, my italics). We do not necessarily have to be in the presence of another person to match bodily and emotional states; we all know that we can respond with fear or sadness to a powerful film, for example. Empathy draws on these bodily and limbic shifts in the process of interoception (Siegel 2007: 168).

It is this embodied quality of mirror neuron activation that is of most interest in our work as trauma psychotherapists. Fogel states: 'The concept of mirror neurons in the neural networks for embodied self-awareness is therapeutically very important because it suggests an embodied approach to working with people who show body schema and interoceptive deficits' (2009: 207), among whom are many trauma clients. Wilkinson (2010: 56) quotes Harrison et al. (2006) who, bringing together different properties of mirror neuron function suggest that they offer a 'common neural representation for the perception of actions and feelings in others and their experience in self *[and a] basis for a neuroscientific account of intersubjectivity*' (my italics; see also Staemmler 2012b: 169). Thus we can consider mirror neurons to be both a property of and function of the field. While this theory provides key understanding of how we 'read' our clients, without which we can't operate, I believe we can also use the concept of mirror neurons to consider our clients' perceptions of us as therapists. Cozolino suggests that for clients who have experienced trauma, mirror neurons are employed to defend rather than to cooperate (2006: 231). This means that trauma clients are more likely to read other people for signs of threat than for approachability, bringing the issue to the heart of the therapeutic relationship. The mirror neuron system is intersubjective, part of the co-created field, and must work in both directions. Clinical experience suggests that the way clients read our bodies is critical to the establishment of safety, trust and a regulated embodied field. 'Our own body process is an intrinsic part of the transaction with the client' (Kepner

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2003: 11). What is being proposed here is that the deep embodiment of the therapist needs continual attention, and that this is not only part of our development as therapists but part of our ongoing day-to-day work.

In order to practise the dialogic stance of inclusion, in which we remain rooted in our own subjectivity while at the same time attending to that of the client, we must be exceptionally clear about our bodily resources. The more resources we have the more the client will pick up on and use, even on an implicit level, through their mirror neuron system. Siegel comments that findings about mirror neurons '*verified the importance for each of us to be attuned to our own internal states in order to attune to others*' (2007: 168, my italics); in any co-created relationship this is bound to work both ways.

Therapist vulnerability

While mirror neurons can be of service in the relationship between therapist and client, they have their downside. We can hope that we learn from our clients about their experience through our own mirror neuron system, and we hope also that our clients can learn about our resourced state through theirs. However, this is also the mechanism by which we pick up on distressed emotions and dysregulated physiological states in our clients, and in working with trauma this can be problematic. There is something about being in the presence of a traumatized person that can make their pain and terror contagious. We need to take especial care of ourselves in order for this not to dysregulate us too badly, and in order to stay as present, available, open and embodied as we are able. And we need to be able to do so without becoming defensive or distant. 'It is best that your system resonated with something other than this [client's] fear. The client is far more dependent on the therapist's resources than is usual' (Cook 2012: 34). There are two main ways in which therapists become vulnerable when working with trauma in particular, and these have implications for the quality of the therapeutic relationship. We will consider these separately, even though in reality they may be layered together in our experience.

Vicarious traumatization

Vicarious traumatization is inevitable for therapists who work regularly with trauma (Perlman and Saakvitne 1995: 281). It is certainly my experience that a handful of particularly graphic tales told me by clients over the years have stayed with me as images holding some emotional charge.

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Vicarious traumatization means experiencing the same signs and symptoms as the client but at sub-clinical levels (Perlman and Saakvitne 1995: 282). Sinason comments thus: 'We have been drip-fed traumatic narratives; we are watched [by clients] to see if we retaliate, get ill, give up. Only when we show that we are still standing is it possible for the next drip to be given' (2008: 84–5). How do we stop ourselves reeling when to work with trauma 'means taking on cruelty and pain on a level we may never have experienced?' (Sinason 2008: 86).

Alongside emotional and somatic activation, the therapist's frame of reference may change, meaning that their view of inherent goodness in the world can be profoundly altered (Perlman and Saakvitne 1995: 282); a trauma perspective can preconfigure perceptions, attitudes and relationships. A sense of moral injury may ensue. Furthermore, the identity of the therapist is affected, raising existential questions: who am I, with my history, experience and circumstances, in the face of my client's? Do I consider myself superior in some way, luckier, or do I seek to find the commonalities between us in order to stay connected? Does this evoke pity, compassion, disturbance, confluence, loss of self-worth or efficacy, detachment?

For example, working with clients with abusive partners tends to evoke gratitude in me for my own respectful and kind relationship. It can be a defensive position, contemptuous even, in which I disengage from my client's unremitting and immediate danger: 'Thank goodness I'm not like you'. Another protective but detrimental strategy is for therapists to lose touch with their body and move into their heads in order to 'manage the onslaught of emotions connected to trauma' (Perlman and Saakvitne 1995: 284). As Sinason, above, implies, the effects of the therapists' vicarious traumatization may register in the therapeutic relationship. These sometimes subtle ways in which trauma impacts the therapy itself need careful attention. While there are bound to be parts of ourselves that we hold back, it is important to recognize that it is not the therapist's theoretical orientation that is as crucial in the healing process as is the wholeness and availability of the self of the therapist (Hycner, 1993: 15).

Personal story 2: feeling wobbly

Alice came into therapy after a very traumatic bereavement and a period in psychiatric hospital. We worked together over many months to stabilize and regulate her symptoms and she had been discharged from all mental health services. Therapy is never a linear process and we had already successfully negotiated a number of challenges. Just as we were moving towards the undoing, redoing and mourning stage of the work, one of

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Alice's colleagues died suddenly, reactivating her original trauma which was still unprocessed. For two weeks I worked hard to provide enough glue and resources to contain Alice through this crisis.

On some level I disregarded my rising anxiety and held fast to my belief in the approach I was taking and to the strength of our relationship. I thought we knew how to get through this together. I did not want to listen to the nagging doubts I had about the differences I now saw in Alice; her loss of contact functions and shaky grip on reality. However, by the third session it became clear that Alice was in a full-blown psychiatric emergency, extremely agitated and not having slept for a week, triggered by violent nightmares and flashbacks to the original trauma. Alice looked very unwell. She was living in a volatile situation, with family and friends becoming very reactive to her deteriorating condition. I took the necessary steps to ensure Alice's continuing psychiatric care. I could at least tell myself that I had done all I could, that I had not given up on her.

But once Alice was transferred to other hands, I found that this didn't reassure me. I was unsettled and alarmed by what had happened; it is always horrible to watch someone you care about fall apart. In the immediate aftermath it seemed as though things were happening in parallel layers of my experience. On the one hand I was absolutely clear that the decisions I had made were right and justified and that no alternative was available to me, while other thoughts were chaotic and disorganized because *I* didn't know where to begin processing this. My breath was shallow and unsteady, I was feeling agitation and distress in my chest and solar plexus, and I felt restless in my legs.

I feared for Alice and the future of our relationship. In the following hours, my thoughts changed from the chaotic to the ruminative and repetitive. I experienced fleeting images and sensory reminders of what had happened; little flashbacks. I felt less in control. I started to blame myself for my helplessness; something bad had happened and it was my fault, a belief familiar to me. I felt that I wasn't a good enough therapist, that I had let my client down for allowing this to happen and I struggled to accept my own limitations, all of which I recognized as quite irrational.

My rational self knew that I had become vicariously traumatized by the situation, and I was able to bring some gentleness to bear towards myself for this. But no amount of kindliness and clear reality-checking could initially settle the level of somatic distress I felt. What helped on a bodily level was my very strong and accessible relationship to my pelvis and spine which proved eventually to offer me a failsafe grounding capacity. So, I could later sit in awareness of both the disturbance in my upper body and the solidity of my lower body, knowing that both were true for me in that moment and that the disturbance was not the whole of my experience.

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The wounded healer

In our day-to-day work with trauma victims we are exposed repeatedly to impressive forces which inevitably have something to do with our own history as well as our clients'. A therapist's susceptibility to vicarious trauma is greater when their own story includes experience of personal or transgenerational trauma; if this describes your interest in working with trauma you will need to pay extra attention to what resources you. Whatever your story, this work demands that we confront those parts of ourselves as therapists that we loathe or fear or ignore, including young, damaged and traumatized parts. According to Orange, I have 'a responsibility to understand my own traumatic suffering as meaningful insofar as it enables me to respond to, and suffer for, my destitute neighbour' (2010: 87). What therapist does not already know resistance and impasse from the inside? We can be pulled uncomfortably out of shape by clients who do not yet understand boundaries, and undermined by clients' attempts to take control. What too, of the therapist's own fear, powerlessness, dissociation and shame? These may arise 'not only in response to narrative, but also to the patient's nonverbal communications and in the bodily movements or facial expressions that accompany flashbacks' (Goodwin and Attias 1999b: 171).

It is easy, for example, to become frightened of a client's unpredictability, especially when it manifests through dissociated aggressive or destructive parts. This can then trigger in us a cascade of helplessness, distancing and shame, whereby we lose understanding and compassion for ourselves and for those parts of our clients that so immediately signal their wounds. 'The way we respond to these [signals] will be pivotal in helping traumatised individuals deal with those difficult sensations and emotions. If we recoil because we cannot contain and accept them, then we abandon our clients . . . if we are overwhelmed, then we are both lost' (Levine 2010: 46). Therapists' embodied awareness and sensitivity to their own process is therefore indispensable: 'Each of us has a different set of behaviours and emotions which we find it difficult to support in ourselves, and others; and we need to know what these are' (Totton and Priestman 2012: 46–7). Above all, in this discussion, we must remember that vicarious traumatization is a response to the client's trauma and not to the client (Perlman and Saakvitne 1995: 300).

The embodied therapist

In order to practise inclusion 'the therapist has to understand the experience of the client, and yet concurrently be able to stay in touch with his

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own experience. It is an exceedingly difficult task to determine which to focus on and when' (Hycner 1993: 16). The emphasis of this chapter is on the embodied dimensions of the felt sense. Fogel considers that 'Practitioners must learn, through their own intensive ventures into the pleasures and pains of embodied self-awareness, to remain in the subjective emotional present and access their own resources while working with someone else (2009: 225). Frank concurs:

> We must attend to our own bodies in order to be aware [of] the client's embodied experience. Does anyone think this is easy? It's not easy to keep going back to one's own sensing and moving while sitting with clients . . . only [by shuttling back and forth] can we 'lend our bodies' to the client, offer our embodied selves as support within the relational field . . . now we are both present and something new can emerge between us. My somatic experience acts as a thermometer measuring the temperature of the relational field.
>
> (2008: 19)

The embodiment of the therapist can be a major resource in the therapy and is essential in the practice of inclusion.

'It takes a remarkable amount of generosity . . . to consider what resources and support a clinician needs, when the clinician is lucky enough to maintain themselves adequately enough to have a job and function in it' (Sinason 2008: 84). This perspicacious comment invites questions: 'How can I know when I have enough resources? What resources am I entitled to?' A straightforward answer is that just as for our clients, we can never have too many resources (see also Chapter 3). I have known experienced therapists become thrown by their contact with some severely traumatized clients, in need of more resources. An embodied therapist knows how to regulate themself, how to restore balance quickly and effectively (see Figure 11.1). In the words of Staemmler, 'we need not only a willingness to identify emotionally, but also a well-developed capacity to regulate our emotions' (2012b: 37). We are talking here about integration of body/mind in the therapist, and their increased capacity to respond and to process in the moment. 'When the therapist's needs are not balanced and when he is struggling and failing to meet these needs in mature ways, he is more vulnerable to vicarious traumatisation' (Perlman and Saakvitne 1995: 309). The range and variety of resources needed by therapists is much as for clients, bearing in mind that it takes years to develop a deep embodiment (Kepner 2003; Fogel 2009: 224). Carroll observes that:

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> The therapist's self-regulatory capacity within the relational context of psychotherapy is critical to their ability to consciously and non-defensively calibrate their interventions . . . The ability to regulate depends upon the therapist being anchored within their own body, able to bear and attend to sensation, and allow spontaneous automatic shifts to occur . . . if this underlying regulation is there then the therapist can also allow herself to be knocked off balance, controlled or confused in the process with the client.
>
> (2009: 102)

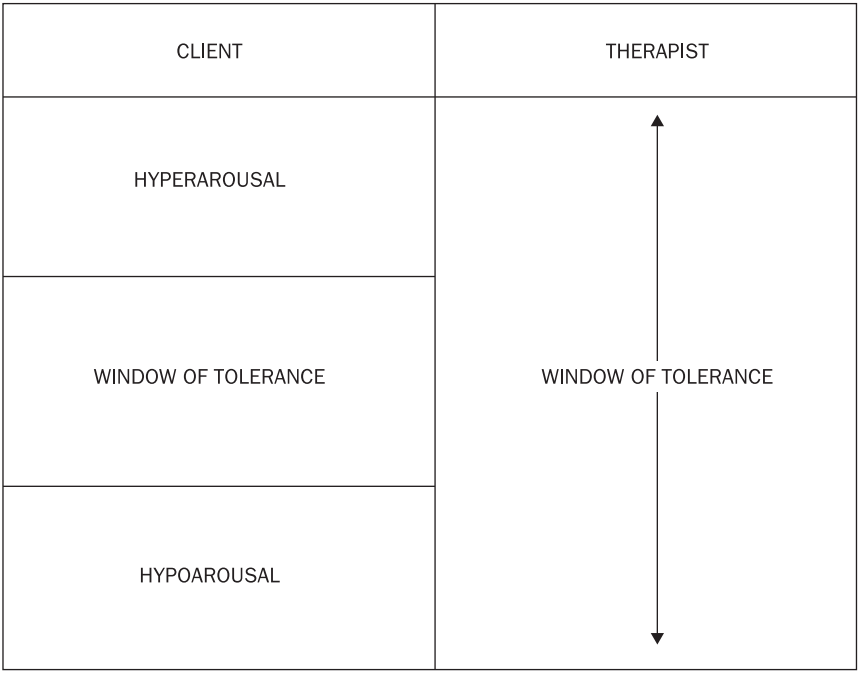

Figure 11.1 The therapist's expanded window of tolerance

Reflection point

Bring to mind the range of resources you have – creative, spiritual, environmental, relational and so on. Which are most important to you? How often do you turn to them? Is there any way you can think of to increase your involvement in these activities or ways of being?

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To what degree are you able to become absorbed in these resources? Which supports your presence most fully? Reflect on the physicality of these resources- which bring you most vividly into a sense of your body? Write about your resources.

Personal story 3: an expanded window of tolerance

I regard the ongoing development and maintenance of my resources as a requisite part of my clinical work, and the hours I routinely spend in doing so as valid work time. More than any other activity perhaps, this is what trauma clients pay me for, to keep myself available to practise as safely as possible. The ethic in this statement is clear. I create healthy gaps between clients, so that I am not left with the energetic residue of a previous session, so that I can clear my body/mind of the content and the process, and reground myself. If I've been with a dissociated or hypoaroused client I generally do some stretches to raise my energy afterwards. I also attend to meditation, exercise, sleep and diet; I avoid consuming heavy food or potential toxins such as caffeine, alcohol or sugar before seeing clients. I nourish myself with art, music, film and nature. Considerable discipline is needed to sustain this lifestyle, for that is what my practice as a Gestalt therapist has called me to: a different way of life. Being human, I also sometimes veer away from this course, and feel a homecoming when I return to it.

My thinking and knowledge base, especially in the area of trauma and the body, is another invaluable resource; a meta-level that provides me with an anchor (Appel-Opper 2012: 90). Allied to this is my use of supervision. When working with one of my first very dissociated clients I was advised to seek specialist supervision, and it remains one of the best pieces of advice I have had. Severely traumatized clients need that implicit knowing of being held in mind by others, and their therapists are supported by greater holding.

These are the parameters, then, of supporting my practice, my functional external resources. I use internal resources when face to face with clients. From moment to moment when I am with clients I monitor the shifts in my presence and physical resonance. Time after time I check on my breathing, on my seat in the chair, on my awareness that signals rising anxiety in me. The first thing I usually notice is a drawing inwards and upwards in my sacral spine, a micro movement that initiates a whole body response in me. It changes my relationship to gravity and almost imperceptibly shortens my breathing: the crus muscles of the diaphragm are connected to the spine. The seat of my energy rises

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and contracts, my thinking becomes more focused as I move into a state of higher alert. Because I rely on this keen relationship with this embodied signal in my small sacral muscles, I can choose to change it and settle back into my grounded and soft spine, or not, as the situation requires. This is the skill of stilling the mind and the body to create a place from which I can listen, a place from which I can maintain my presence and hold my ground while attending to other – in other words practise inclusion.

Reflection point

Take some minutes to scan your body and see if you can find a place that would be your first signal that your regulated state is changing. It can be very helpful to try to reverse the process in your mind: 'This I know, but what happens just before that . . . and just before that?' Pay close attention to the minutiae of your experience. Feel your way into this awareness, experimenting with curiosity, settling your attention in this area. Ask yourself what the message from this part of your embodied self is, how it can support you, what it needs. Allow yourself to soften into your responses without judgement. Explore the quality and texture of your felt signal, its intensity and volume, its impulses and intentions. Deepening your exploration, shift from bringing your awareness to this place to letting this place be aware. From this awareness, establish a sense of connection with how the rest of your body responds to this signal. There is no need to hurry this important process of discovery; allow yourself to stay with it for as long as your curiosity remains alive.

Returning to the earlier exercise, The Witness, conjure up once again the object or client you attended to. Spend some time shuttling your attention to and fro between your internal embodied signal and this external feature. As in learning any new skill, it takes a great deal of practice to get the hang of this, and you are encouraged to practise at any and every opportunity in the coming weeks and months, including during sessions with clients. Once you have integrated this skill it need not distract you. This shuttling process is not unlike the self-function of dual awareness that we foster in our clients.

Some general categories of embodied resources involve grounding, containment and breath. What follows are experiments for each.

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Experiment

1 Constructive rest

Lying on your back on the floor, close your eyes, bend your knees; let your feet rest on the floor, slightly wider than your hips; let your knees drop together to release your thigh muscles; rest your arms comfortably on the floor, below shoulder height; allow yourself to be supported by the floor; allow your breath to move three-dimensionally through your torso; allow your eyes to rest in their sockets like pebbles dropping into a pool; allow your brain to rest in the skull; allow the shoulders to melt towards the earth; allow the weight of your legs to drain into your hip sockets and feet; allow your organs to release towards gravity; allow your mouth to gently fall open, your tongue to relax; feel the air move in and out through your lips and nose.

In constructive rest instead of controlling the body you allow it to be supported by the earth. As you release your body weight into gravity, your discs are less compressed and your spine begins to elongate. Constructive rest is an efficient position for body realignment. It releases tension and allows your skeleton and organs to rest, supported by the ground. Done for five minutes before falling asleep, the relaxation returns the body to neutral alignment, so that you don't sleep with the tensions of the day.

(Adapted from Olsen 2002: 4)

2 Walking down the spine

If this experiment becomes difficult to do, try imagining yourself doing it.

Seated, body weight balanced over your pelvis, eyes closed: feel your vertical plumb line. Do a small 'yes' nod with your skull to find the connection between your skull and your atlas. Begin rolling your head down your spine, vertebra by vertebra. Imagine that you are walking down a ladder, curving each vertebra as you step. Use your fingers to touch the vertebra you are moving.

Touch the base of your skull. You will find an indentation, which is your atlas. Roll your head forward from your skull and atlas. Breathe deeply, keeping awareness on your fingers.

Walk your fingers down to each of your vertebrae one at a time – seven cervical, twelve thoracic, five lumbar and five

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fused sacral vertebrae. Roll your head forward from each axis you arrive at, breathe deeply and continue on down. Release your hands where it is uncomfortable to reach and use them again once you can touch the area in question. If you are unsure, approximate and keep going; you are still bringing sensory awareness to the area.

Now you have arrived at your sacrum, the five fused vertebrae which form the keystone of your pelvis. Place your hands in the centre of your pelvis and feel this triangle of bones as you breathe. Use your fingers to touch your coccyx, the base of your spine, your ancient tail. Your spine is fully curved forward from your skull to your tail, like the ancient symbol of the snake eating its tail. Feel the curve.

Return your coccyx and sacrum to a straight plumb line. Feel your weight drop down in order to come up. Begin counting up your vertebrae, moving each one back into the plumb line: 5th lumbar, 4th lumbar . . . 12th thoracic, 11th . . . etc., up the seven cervical vertebrae and then bring your skull back to plumb line. Tap the top of your skull and imagine your head extending the vertical axis.

(Adapted from Olsen 1998: 53)

3 Pelvis

Trace the shape of your pelvis from the iliac crest below your ribs round to your pubic bones – pubis and pubic symphysis. Roll on your side, starting again at the iliac crest, tracing the bone round to your sacrum, feel your sacroiliac joint. Massage through the tissues of the gluteal muscles to the hip joint (acetabulum), and locate the neck of your femur and greater trochanter. Continue down the back of your pelvis to the ischial tuberosities (sitting bones). Flex your leg if necessary and trace from your sitting bones to your pelvis between your legs – the ramus of the pubic bone. Roll over and repeat on the other side. Rock on your sitting bones and feel the shape of them against the chair. Initiate rocking from your iliac crest, initiate from your pubic bones, from the sitting bones, from the pelvic floor. Circle your pelvis, imagining swishing water around inside a bowl. Reverse directions. Seated, walk on your sitting bones, keeping your legs relaxed, reverse direction.

(Adapted from Olsen 1991/1998: 85)

There are countless ways of focusing attention on breath, and you are encouraged to establish a regular practice involving breath awareness. This is but one method to help you:

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4 Lung breathing

Lie in constructive rest, eyes closed. Notice air coming in through your mouth and nose. Feel the air passing down through your throat to your trachea, a long tube ringed with cartilage, supporting the front of your neck. Touch your neck lightly to feel this structure. Place your hands on your belly and allow it to expand on the inbreath and condense on the outbreath (without pushing). Imagine the shortening of your crus muscles at the back, pulling the strong central tendon of your diaphragm down towards your lower spine. Place your hands on your ribs. Notice them fanning out on your inbreath and softening on the outbreath. Allow all twenty-four ribs to move as you breathe. Notice your breathing pattern. Enjoy a few deep integrating breaths to finish your exploration.

(Adapted from Olsen 2002: 117)

Mindfulness as a resource

The experiments in this chapter, and indeed many of the experiments throughout this volume, involve mindful awareness, the process of attending moment by moment and without judgement to subjective felt and embodied experience: 'It is the subjective experience of the therapist that is often the key factor in the therapeutic relationship' (Hilton 2012: 28). Gestalt experiments in directed awareness are a form of mindfulness practice and more structured forms of practice are possible, involving either focused or open attention (see also Chapter 5). Mindfulness is a primary tool for establishing greater body awareness and of stepping back from experience, both for ourselves and for our clients. For a full understanding of the role of this issue, I commend to you Dan Siegel's *The Mindful Therapist* (2010). Siegel illustrates the roles of integration, resonance, coherence and attunement that emerge from mindful states, and the impact of these on both therapist and client.

I suggest that mindfulness increases practitioner resilience and relationality, essential to trauma therapy: 'The ability to tolerate the truth of the traumatic experience involves a capacity to bear pain in the presence of another human being; this constitutes the core of mature intimacy' (Turner et al. [1996] 2007: 538). Furthermore, 'therapists' mindfulness contributes to critical relationship factors such as the formation and sustenance of the working alliance, countertransference management, and the provision of unconditional regard with difficult clients . . . the more mindful therapists perceived themselves to be, the less aware

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they were of their countertransference' (Davis and Hayes 2011: 204). Staemmler argues similarly for the usefulness of meditation practices in prevention of practitioner burnout (2012b: 226).

Mutual healing

This might appear to be an extraordinary claim, but much therapeutic work with trauma victims can be pleasurable. It should be so, for it is an indication that you are doing the work of regulation and interrupting the figures of trauma. Although this is not the whole of the therapy, the significant role of reciprocal resourced states brings benevolence and compassion to the work (Staemmler 2012b), creating an energy field that is soft, deep, attentive and receptive. This must develop in a way that is genuine because clients will be quick to spot when it is not; this is work that is not forced or artificial, but allowing of emergent relational phenomena. These are the I-Thou moments of therapy; they serve as markers in the ground, growth points, strengthening the alliance and opening up new possibilities. They 'can be considered pivotal relational influences that occur as a result of critical subjective colouring of experience on the part of both participants in the therapeutic encounter' (King 2012: 75).

More than this, '[w]hen the patient experiences true healing, it often serves to heal the wounded pole of the professional healer' (Miller and Baldwin 2000: 251). Hilton deepens this argument: 'As the therapist accompanies the client on his journey back to the origins of his interactional failures, the therapist must know and understand her own relational failures and the solutions she sought for them. This dynamic interplay and all that is implied in it becomes the healing process for both therapist and client' (2012: 33). In respect of trauma therapy, we can consider these failures to be the gross disturbances in the organism/environment field which constitute trauma. Therapists who bring their embodied selves, their whole selves, to the relational encounter risk so much and stand to gain so much; it is my experience that the gains outweigh the losses.

Summary

The selfhood of the therapist as one partner in the therapeutic dyad is an important consideration in all therapy, but there are particular reasons for paying attention to this in trauma work. Mirror neuron theory suggests neural mechanisms that enable resonance and empathy between individuals. It is suggested therefore that mirror neurons are the neurological component of relationship. Usually,

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mirror neurons are held responsible for the therapist's attunement to the client, but it possible to consider that the reverse is operating, when the client's mirror neuron system is activated by the therapist's embodied and implicit resources. This is but one rationale for developing one's own accessible somatic resources.

The second reason is that the mirror neuron system is likely to be implicated in vicarious trauma, the sub-clinical residue of the client's traumatic material which can disrupt and reconfigure the therapy and the therapist's view of the world. This can also tap into the therapist's own history of trauma and relational wounds, creating a vulnerability to additional distress. The case for developing a wide range of resources is made, in order to enhance therapist resilience in trauma work. Particular attention is given to those somatic resources which reflect and support a deep embodiment, enhancing the dialogic dimensions of presence and inclusion. When the therapist is able to include both awareness of the client and at the same time remain anchored in their own integrated experience, the relationship is supported and strengthened. It is also possible for moments of healing in the client to include the healing of the therapist.

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12 Embodied relationship

Being in a therapeutic relationship with a trauma victim is very often enormously complex and challenging for both partners. Whether recent or historical, the trauma will have profoundly challenged and shaped their sense of self and other, their connection to the world and their capacity to connect. These issues speak to the very heart of the therapy relationship. Above all, trauma victims need to be able to tolerate being in relationship in order to heal. This chapter explores concepts of resonance and regulation from a relational viewpoint. The Window of Tolerance Model is re-positioned as a relational framework. Examples are given of non-verbal relating to trauma clients, attending to their embodied **contact styles**, strengthening the working alliance. So we explore some ways of establishing the embodied relationship, including the use of touch.

Relational dilemmas

One client keeps his coat on throughout the session; he has arrived but not fully. Another keeps glancing anxiously at the door, as though checking for an escape route. A third learnt as a child to dissociate to 'a place where no one can find me' and does so repeatedly in sessions, such is her terror of being 'found'. Many of the themes of trauma come into play in the therapeutic relationship. Chaos and rigidity become structurally embodied as contact styles, as do mobilized and immobilized defences. As an example, a client who is unable to tolerate the immobilization of trauma *can* actively control and attack the therapist, which is a semblance of power. The fast-moving figures of a chaotic client can be extremely difficult to disentangle and reorganize; we seek coherence in order to make some meaning but it is like grasping smoke, the gestalts incomplete and unformed. Themes of fear, helplessness, disconnection and shame pervade and dominate the work. Perceived cultural norms in the form of taboos, secrecy and verbal

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threats operate alongside bodily based beliefs about self in relationship and finding one's place.

How do you include the client as a participant when they are preoccupied with defending themself against exclusion? How do you establish collaboration with someone whose experience is of being overcome by some outside force or individual? How do you make an impact on someone who is well armoured against intrusion, or who doesn't expect to make an impact on others? How can you feel into the world of a client whose speech and language are divorced from any emotion, the trauma narrative delivered as though they are telling you what they had for lunch, where 'language holds the potential to trigger an affective reliving of dissociated traumatic experience' (Bromberg 2011: 17)? Many of these dilemmas arrive as multilayered and while connected can be very difficult to unravel. There is a relational message in each of these behaviours, which needs to be brought into awareness and made sense of together, and we will return to this below. This task is particularly figural for those clients with complex trauma, which usually involves considerable damage to their capacity to be in contact with others.

What we already know

At its most basic level, all relationship can be seen as an exchange of energy (Siegel 2009: 166), involving sound and light waves. Many auditory vibrations occur at decibels that cannot be detected by the human ear, and we can imagine their effect beyond awareness. Further than this, the nervous system has energetic properties, transmitting information and triggering awareness and all manner of chemical, emotional, sensory and muscular responses throughout the body/mind. Electrical currents within the body are captured in EEG and ECG tests (Brennan 1988: 20). Cells, in a state of health, luminate and pulsate (Boadella 1987: 181). In the natural world, homing pigeons detect the electromagnetic fields of the earth, responding to changes in gravity and barometric pressure, and sting rays sense tiny electrical currents when a muscle contracts – even a beating heart – via electro-receptors which detect the presence of prey. Who is to say that we humans do not have such acute capacities as yet undiscovered? Although controversial, Kirlian photography suggests the presence of a subtle energetic field which has been of interest in understanding psychic and paranormal activity for many years.

There is much that we have yet to learn about human energy fields and how they interact, nevertheless such interaction is a useful concept for psychotherapy since subtle energy is a field phenomenon (Kepner 2002). We all know how to 'read' the atmosphere when we enter a room,

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when someone approaches us from behind, or we have taken an instant liking to someone; most people can also recall instances of having had a 'sixth' sense, or of surprising synchronicity or coincidence. As a supervisor, I noticed on several occasions that I yawned when a particular client was discussed. It turned out that this was clinically useful information, but how was this being transmitted to me? In what ways, if any, was my supervisee a mediator of this unconscious communication by someone I had never met?

Brennan suggests that universal energy fields (belonging to all things, animate and inanimate, of which human energy fields are a part) have synergistic properties – meaning that the whole is more than the sum of the parts and is always associated with some form of consciousness (1988: 40). According to Kepner, conscious awareness has energetic properties, consciousness being embodied via the pathway of the nervous system (2002: 4). Resonance speaks to something being implicitly known in the relationship (Lyons-Ruth et al. 1998). This is more than attunement, a unidirectional process by which we align ourselves to the wavelength of our clients, it means allowing the client's energetic communications to reverberate within us. Clemmens speaks of his vibration in resonance with his client (2012: 42). It is worth emphasizing that the implicit is always embodied.

Experiment

1. Find some pieces of music that have different resonant qualities. Suggested are: *Itaipu I: Mato Grosso* by Philip Glass; *Golden Bowls* by Karma Moffett; The Drummers of Burundi; 'Prayer from The Orphan's Lament' by Huun-Huur-Tu; *Spem in Alium* by Thomas Tallis. Lying on your back, listen to these and allow the sounds to resonate in different parts of your body. How do they vibrate within the hollow spaces of your body – your skull, your mouth, your throat, your chest, the bowl of your pelvis? How do they reverberate on your skin, and where is this most clear to you? Notice the variations in pulses and your response to each.

2. Lie on your belly on the floor, with your forehead raised slightly. Create a closed bowl by cupping your mouth, one ear and the floor with your hands. Make the open sound 'ah' and sense the vibrations in your face. Continue and notice vibrations in your head, arms and torso. Make the closed sounds of 'ng', 'n', 'mm', and sense those vibrations. Play with other sounds. Where in your body can you move the vibrations to? What sounds vibrate the most? The least? Exaggerate the consonants. Exaggerate the vowels. Tell a story out

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loud, perhaps what happened this morning, continuing to sense vibrations. Pause. (Adapted from Olsen 2002: 82)

3. Lying on your back, take a few deep breaths. Slowly sense the contact you are making with the floor and settle into the sensation of contact. Take a few more deep breaths holding a wide field of receptive awareness of your whole body. Maintaining this wide field of perception, allow your attention to come to your physical heart. Simply orient to its pulsation. Place your hands over your heart if its pulsation is not clear. As the beating of your heart clarifies, again widen your orientation of listening to your whole body. See if you can, while not losing an awareness of your heart itself, sense its pulsation in different parts of your body. Can you sense it in your abdomen? In your belly, legs, chest cavity, arms, neck and elsewhere? Allow a more general sense of the pulsing of your lifeblood to arise while staying centred in your heart. (Adapted from Sills 2011: 77)

Schore explains that '*Resonance* phenomena are now thought to play one of the most important roles in brain organization and in central nervous system (CNS) regulatory processes' (2003b: 51, original italics). Resonance is not a merely passive process and likely involves mirror neurons (Staemmler 2012b: 163). We can think of the practice of inclusion as dependent on resonance within the energetic field. In order to support neural integration we need to create 'mindful fields', those in which the client is held in mind by a coherent and mindful other. This involves a recursive generation of safety and internal attunement (Harris 2011: 27) – the internal and external sense of safety that comes to replace terror (see Chapter 6). Kornfield observes that 'the best of modern therapy is much like a process of shared meditation . . . the therapist joins in the listening, sensing and feeling'(1993/2002: 245).

What, then, is the clinical significance of resonance? Primarily, the concept is relational, as suggested by Boadella: 'the most essential tool, in transforming blocked patterns [of energy] is the responsive life of another human being' (1987: xv). Staemmler quotes Stein: 'by his walk, posture, and his every movement, we also "see" "how he feels", his vigor, sluggishness, etc' (2012b: 38). The mechanism for resonance is thought to involve unconscious communication between the right brain of one party to the other's right brain that is '*tuned to receive these communications*' (Schore 2003b: 49, original italics). Thus a degree of synchrony between the members of the dyad is necessary, which is inherently embodied. We can imagine this synchrony to be mutually reinforcing in the therapeutic dance. This is summed up by the words of Lyons-Ruth (2000): 'I sense that

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you sense that I sense'. According to Sander, organization of the structures of self is an emergent property of the dyadic system, rather than solely of the individual (cited in Beebe and Lachman 2002: 156).

Each individual is a self-organizing system that creates its own states of consciousness – states of brain organization – which can be expanded into more coherent and complex states in collaboration with another (Tronick 1998).We can learn from this that the reorganization of self into a coherent and integrated whole must be supported relationally; after all, the self that has formed following a trauma is a different response to a different field. Resonance describes the quality and match between partners in the dyad: it is an interactive process of two closely attuned systems which allows them to amplify and co-regulate each other's activity (Siegel 1999: 336), the influence of which 'persists within the mind of each member after direct interaction no longer occurs' (Siegel 1999: 281). For this to happen there needs to be a compatibility between the individuals involved, a process of coming alongside the client in their trauma.

I was seeing one client in the late afternoon throughout the winter months. The season was changing and I realized one day that her session would start in daylight and end in pitch dark. I 'knew' it was important to check with this particular client whether she wanted the curtains open or closed. Her solution was to have them half open. She referred to dark figures outside the window which she had never mentioned before; it seemed to her that they might come into the room. Later in the session she allowed me into the story, for the very first time, of her mother's emotional neglect of her, to the point of deprivation and crushing of her own emotional self. The resonant intersubjective field is an energetic container in which the client and the trauma can be held. Any unsignalled withdrawal from that resonant field by either person will disrupt the other's state of mind (Bromberg 2001: 193), such as when a new figure emerges for either party.

Mutual regulation

Much research into the interactions between infants and their caretakers has become the territory of applied neuroscience, and are taken to be prototypes for adult psychotherapy (see Stern 1998; Tronick, E. 1998; Beebe and Lachman 2002; Schore 2003a, 2003b). These writers take a dyadic or systems view of the regulatory behaviour between mother and infant or therapist and client; 'the dynamic engine of the therapy lies in the self-organizing properties of analyst and patient together as a dyad' (Boston Change Process Study Group 2010: 97). Intersubjectivity theory puts this thinking into practice, in what can be seen as a four stage process:

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(i) I support myself (ii) in order to support you (iii) in order to support yourself (iv) in order to support me. This is a system of reciprocal mutual influence (Stolorow et al. 1987: 42).

We have already established the case for trauma clients to develop ways of re-balancing the dysregulated arousal that is so prevalent in their experience, via the use of resources and an expanded window of tolerance. This process of re-balancing is what Gestalt therapists understand as organismic self-regulation (Perls et al. [1951] 1998), the process of self-regulation being so compromised in trauma clients that they need to rely initially on the help of the therapist. We have seen in Chapter 4 how this natural process is rendered inaccessible by traumatic experiences. Often trauma victims self-support by means of withdrawing energy from the field; an overly self-reliant stance that allows little space for contact, because the field is perceived as too dangerous to support their existence. The work of Tronick suggests that too much focus on self-support sets the stage for psychopathology (cited in Beebe and Lachman 2002: 162). For trauma clients this can be tricky, for allowing anyone else to do something for them may feel like a betrayal of the self (p.193). Gestalt therapy also distinguishes between self and environmental support, which speaks of the interaction of self and field.

A relational perspective in Gestalt therapy puts increasing emphasis on the interconnectedness of self and other, understood as a co-created, intersubjective therapeutic space. For trauma work it is helpful to think of this as co-regulated.

> The principles that apply in individual self-regulation also apply to the therapeutic pair as a couple. The two-person system is a dynamic balancing act, with the level of feeling often fluctuating as the interaction between client and therapist is managed both implicitly (through self-regulation and interactive regulation) and explicitly (as far as these processes are the subject of verbal exploration).
>
> (Carroll 2009: 103)

If self-regulation is 'a way of perceiving and knowing and understanding'(Carroll 2009: 103), a way of knowing through the body, then mutual regulation is a way of perceiving, knowing and understanding one another through their bodies.

Clinical vignette

Stuart comes to see me straight after work. He tells me: 'My boss was in a foul mood today.' Tightening in my lower back, I pull forward a

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little from the support of my chair; my breath is shorter, centred in my sternum; I notice a vibration in the skin of my throat as though it is ready for something. Simultaneously, Stuart looks briefly at me and then down and slightly to the left. The energy between us feels loaded. He takes an effortful breath, and when he speaks his voice is strangled, measured. 'Yeah, made me feel uneasy . . . tried to keep out of his way . . . but he . . . wanted to talk to me about something . . .'. I maintain my gaze, and nod to convey my understanding that he is saying something important. Stuart glances at me again and then looks out of the window; he's a bit less present now.

In this moment I settle my breathing, drop my weight back into the chair; I feel more receptive. 'What was it like for you in this?', I ask; my voice is soft and steady.

'Scared . . . I felt scared he was going to lose it,' Stuart replies; his hands are tightening in his lap but he seems more connected. I feel this in my chest, a pressure, and some tension developing across my collar bone and upper arms; I take a deeper, more audible breath.

'Oh, I see . . . are you willing to tell me more?', I respond. Stuart's energy rises.

'Yeah . . . yeah . . . I was afraid . . . felt terrified, anxious . . . like I was smaller, and . . . and . . . like he was going to hurt me . . . my dad . . .'. Stuart shifts slightly in his chair, straightens his posture, gently rubs his thumb on his leg a few times, looks at me. The energy which was held now seems to open; we engage a soft eye contact, breathe steadily together for a few seconds before we move on. It was not necessary for me to verbally share my responses to Stuart in order for the mutual resonance to be felt.

As Fogel remarks: 'Any kind of coregulated activity with another person is a way of establishing a felt connection' (2009: 223) thereby linking regulation and contact. Each participant must 'come to know' the current state of the other if the regulation is to succeed (Tronick 1998). In this both parties are implicitly reaching for integrated nervous system states that support over time the creation of coherent narrative (Wilkinson 2010: 134). As the example above shows, regulatory processes are fast, often below levels of consciousness; they are intuitive, empathic responses to the other in the room (p. 33). Further, '[m]utual regulation implies no symmetry between the interactants, only that influence is bidirectional' (Boston Change Process Study Group 2010: 8). Fogel describes such shared emotional states as awareness expanded beyond the boundaries of the body (2009: 224); this thinking critically redefines what we mean by 'owning' our bodies because they belong as functions of the field.

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Non-verbal features of mutual regulation by either the therapist or client include aversion of eye contact, turning of the head, small gestures of self-touch, contraction and expansion of energy, prosody of speech, mood, the intensity of emotion, silence, breath, and changes in muscle tonus or skin colour or quality, among others. This list can be seen as an expanded phenomenological description of contact functions (Joyce and Sills 2010: 59), the pulsation of lived therapeutic engagement, usually representing habitual patterns in a form that is subtle yet recognizable by the other. We sense these phenomena via our nervous systems. These processes relate to what Siegel calls the 'social brain', creating subcortical shifts that literally resonate with what is being perceived (2012: 19-7). Such moment by moment adjustments to levels of arousal are an intrinsic part of contact. There needs to be a reasonable match between the regulatory range of each participant (Beebe and Lachman 2002: 220). Importantly for trauma victims, the client, by virtue of her impact on the therapist and the reciprocated response, becomes an agent in the therapy when the regulation is co-created.

Mutual regulation and the window of tolerance

Far from being a singular and biological model, it is more profound and creative to understand the concept of the window of tolerance as a means to restore the victim to relationship within a field which has been so painfully fractured by the traumatic event. We can think of mutual regulation as a way of bringing *both* parties into a shared state of optimal arousal – the window of tolerance. Optimal arousal thus becomes optimal support. The implications of this are enormous when we recall that it is only within the window of tolerance that the client is truly present and available for contact. Thus we can also suggest the cycle of experience as a model for co-created processes. Furthermore, the client is unable to process the trauma unless their access to the window of tolerance – or availability for contact – is reasonably reliable, and this access needs to be relationally mediated. Therapist and client collaborate on expanding this zone, using one another's support to explore the margins of the safe emergency wherein processing of trauma becomes possible. The window of tolerance is not therefore simply a calm and confluent condition (Delisle 2011: 83), but a state of being together in which things can happen.

In Chapter 6 we saw that the working alliance with trauma clients needs to be constructed around the issue of safety, both environmental and internally sensed. The Window of Tolerance Model provides a conceptual framework for relational safety. Introduced early in the therapy,

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perhaps as part of the contracting process, it helps clients in an implicit way to feel understood. The model speaks directly to their lived experience of dysregulated arousal, something that they can identify with and that normalizes and confirms their experience.

Even where the window of tolerance is seen initially as inaccessible and beyond personal experience, it offers some hope in the possibility of a different state of being. In presenting the model, the therapist can use language that indicates its relationality: 'I have some ways to explore this idea together'; 'I'll need you to teach me about your ways of coming in and out of this zone'; 'we can find out what is helpful and what isn't'. Far more importantly, it is *you*, the therapist who conveys the message, not just in words but in your being. Together, you negotiate the boundaries and continually redefine the space.

Trauma clients are often consciously watching for what we can tolerate (Sinason 2008: 84), waiting for us to be able to bear their trauma with them. For them, the risk that they will not be received, believed, or held in the rawness and horror of their experience is immense. The risk is of rejection, alienation and disintegration. You may likely recognize that the more experienced you have become as a therapist the more clients will share. Their process of 'drip feeding' information is their way of keeping us both in the window of tolerance. Again this is a mutually regulating cycle: if I can bear something as a therapist, it makes it more bearable for my client, and the next figure can then be borne. Incrementally, a sense of safety develops, a sense that we can together recover from the waves of trauma that can engulf us. This is therefore also a model for the foundation of trust.

An experience beyond words: making sense together

There are countless ways of making aspects of the client's embodied trauma relational, the success of which I suggest depends on the therapist's ability to access their own integrated embodied resources (Chapter 11). To use the words of Totton and Priestman, we need to 'somatise the relationship' (2012: 37). The 'therapist must be able to hold a constant awareness and appreciation that the body is intrinsic to *all* human process' (Kepner 2003: 9, original italics). It is impossible to be prescriptive about processes that emerge through the emergent intersubjective phenomenology in the moment, fast and often subliminal as they may be. What follows, therefore, is some thinking about relating to the client's body/mind, limited by space, and descriptions of clinical work.

It is very common for otherwise articulate trauma clients to be unable to express their felt experience verbally. Their emotional life is

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undifferentiated and vague (Orange 1995: 91). The technical word for this difficulty with verbalization is alexithymia, which involves impaired ability to identify the somatic components of an emotion, to know what they mean, or to use them as a guide to appropriate actions (van der Kolk [1996] 2007: 193). Alexithymia is a manifestation of the deep disconnection with embodied life which is characteristic of trauma. It is also associated with disconnection in relationship: 'The ability to link feelings and words . . . relies on relationships to build connections between separate neural networks dedicated to affect and language' (Cozolino 2006: 231). Based on our understanding of the dominance of the limbic brain when a person is reminded of trauma we might expect that verbal representation will be impossible (see Chapters 2 and 6). For some individuals verbal expression and meaning-making is more generally compromised, recognizable in those who habitually use a cognitive style of processing experience. For trauma clients this may arise from their intense fear of the physicality of any emotion, which in turn increases ANS activation.

There is a specific neurobiological explanation for this. It has been demonstrated that a brain structure called Broca's area, situated in the left cerebral cortex, which is responsible for translating experience into language, becomes underactive during exposure to traumatic material (van der Kolk [1996] 2007: 233; van der Kolk 2003: 187; Ogden et al. 2006: 237). It is not necessarily the case that such clients do not feel; they may know that they feel physiological arousal, but cannot communicate or process it (van der Kolk 2003: 187). We must assume that the body is more capable of knowing than can be put into words. This can leave clients helpless, alienated from the sources of human comfort and understanding that could offer them healing. This speechless terror needs to be met on a different level, corresponding to those levels of the brain that are functioning (Heitzler 2009: 178).

Trauma comes to be known through the presence of the therapist.

> The nonverbal world of our shared communication is often an essential place to begin to make sense of our subjective lives . . . all of the associations, beliefs, and cognitions [of unresolved trauma] can be held within the spotlight of attention – even without words – such that this shared experience can enable memory retrieval to begin to become a form of memory modification.
>
> (Siegel 2012: 39-8)

The client is no longer alone with their trauma. The ubiquitous Gestalt enquiry 'What's happening now?' is rendered useless in moments in which sensations are undifferentiated and words inaccessible. Rather, the methodology of phenomenological description is preferred for creating an embodied narrative.

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To give an example, a client new to therapy could not access physical sensations that she could make any meaning of. I began by naming her observable body process that accompanied states of distressing memory: 'I can see that you are pulling your arms tight in . . . your breathing has become more shallow . . . you turned your head', using statements rather than questions to create a narrative of how she organized herself somatically in the moment. The client nodded silently in response to my interventions, as though she was able to observe and consider these phenomena herself, creating somewhat more distance from the experience. I understood this as a negotiation between my client and myself, involving increased coherence in the relational field (Boston Change Process Study Group 2010: 195). My recognition led to her own, and moments of reflective awareness became possible. Over time I made my descriptions increasingly precise as we learnt her body story together. I added my own resonant responses at times, such as: 'You have become still on the outside but I get the sense that there's a lot going on inside at the moment', whereby she could apprehend her effect on me. We were working in a provisional space – the slow forming of coherence, integration and differentiation.

Another relational way to work with body process is to 'take on' the way the client embodies him or herself. On the one hand, it offers up invaluable information when the therapist has a first-hand map of how it feels to be inside the client's body in the world, the residue of which will linger beyond the completion of the experiment. On the other it communicates important relational messages to the client. I am not talking here about mimicry or even kindly imitation (Staemmler 2012b: 97), but about showing the client that you want to know what it is like to be them, allowing them to 'feel felt'. To do this requires mindful attention and some fine tuning, seeking the client's collaboration to get the tension in the back, the distribution of weight in relation to gravity, or the angle of the head 'just so'; it is surprising how often they recognize it once they see it.

To take on the whole of the body may be too obvious, too gross an experiment at first, but aspects such as the clenching of hands in the lap can be explored together in this way. When the therapist offers feedback on their experience and understanding, the client in turn has an opportunity to 'try on' those words to see if they fit or not. Implicit in such an experiment is the therapist's willingness to feel into the client's structurally embodied wounds, their somatic creative adjustments. This is profound non-verbal confirmation, with far-reaching implications for the safety and depth of the relationship.

Many of the experiments on developing body awareness throughout this book can be used with clients in a collaborative manner. For example, I used a variation of the experiment given in this chapter on reverberations in the body with a young client, making the sounds myself into his

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back while he lay on his stomach. Simply suggesting that you spend a few moments together attending to breath creates a shared mindful field. I often offer back some detail of my somatic awareness, which can allow the client to own their phenomenology of the moment. Because this work is so dependent on right brain processes we can rely on our creativity to adapt to the situation. It is sometimes astonishing when we listen with our embodied selves to feel oneself drawn to a particular pain, for example, in a client that has not been spoken of. In these subtle ways the client guides us to the unknown figures, co-creating the experiments.

In this work we are not trying to dispense with spoken dialogue but to find an entry point into a number of self- and relational functions, often out of awareness. Among these are developing embodied self-awareness, establishing new learning through collaboration and negotiation relationally, the owning of experience that begins to form a new sense of self, reorganizing of traumatically held experience, and strengthening differentiation and coherence, alongside opening up the integrative capacity of language. Boadella describes this integrative function as 'the fusion of the body-stream and the word-stream' (1987: 123). According to Wilkinson, we need to build a new narrative 'that is not so unbearable that it has to be split off again' (2010: 11). Pennebaker reports that health and cognitive function improve as a result of journal writing (1997), which seems to involve complex integrative processes of verbalization, stepping back and reflecting and following the continuity of experience.

The more complex the layers and modalities of experiencing involved, the richer, more stable and more coherent the narrative will be. 'While language is increasingly incorporated into these [relational] encounters with development, the structure of the encounter itself may never be represented in words. It is simply enacted and grasped implicitly in its enacted form' (Boston Change Process Study Group 2010: 69). The emergence of the story has only a partly formed shape as it is worked and reworked, held lightly for some considerable time, which is consistent with the hologrammatic process of Kepner's Healing Tasks Model (1995). Equally, the body may never reveal its story in a form that can be represented by words, and a different subjective meaning will arise from that.

Experiment

Turn your focus inwards, and let it rest with whatever bodily sensation draws your attention, pleasant or unpleasant. Take a few moments to investigate your experience and try to find, say, six adjectives to describe it. Think in terms of the qualities of tension,

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energy, pulsation, weight, space, depth. Use these ideas to begin to compile a list of words to describe sensations, aiming for forty or more. You could use some of these words as prompts with clients to help them differentiate sensations for themselves.

The trauma therapist's hand needs to hover continually over the pause button, as it were; the skill of interrupting the client being an integral part of his or her stewardship of arousal (see Chapter 10). This allows for close attention to the client's internal arousal as well as to co-regulatory processes within the system, the moment-to-moment process which carries the therapeutic leverage (Beebe and Lachman 2002: 218). It is easy to misinterpret a client's embodied communications when there are no words to accompany them; there is wisdom in stopping and listening afresh to what is unfolding. A client of mine appeared to be on the verge of freezing into a dissociative state, and believing that she was reliving some terror I worked diligently to invite her back into contact with me, to no avail. This happened again over several sessions until she was able to tell me that my efforts reminded her of people trying to force her do something. Her freezing was not directly connected to the past, but to a misattunement in the here-and-now relational process between us.

Touch

Touch in psychotherapy is deeply controversial, because it 'can leave open the possibility for grave misuse' (Kertay and Reviere 1998: 20). Few therapists are well trained in the practice of therapeutic touch, and different schools of thought become quite entrenched and polarized around the issue. It is true, nevertheless, that ethics evolve, '[s]ocietal consciousness changes; the position of psychotherapists in society changes; and research informs us of false data that have been translated into ethical pronouncements' (Smith 1998: 50). It is as indiscriminate a position to forbid touch in a psychotherapy setting as it is to hold a client's hand whenever they cry. After all, in the words of Staunton, 'There is no evidence to suggest that touch or physical contact with clients increase the likelihood of acting out sexually, nor that distance or analytic rigour prevent it' (2002: 75).

When we place so much emphasis on the role of the body in working with trauma it would be perverse not to give this most human communication some serious thought, ethical considerations notwithstanding. Issues about the appropriateness of non-erotic touch, whose needs it serves and the giving and withdrawing of consent must not be overlooked because

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they form the ground from which touch might safely be used. Figurally, though, we need to weigh up the potential therapeutic value in offering particular touch to some individual clients against withholding it. Ogden et al. suggest three parameters for the use of touch in trauma therapy: it must be well considered, boundaried and therapeutic (2006: 201).

Touch is one form of human connection which triggers the release of the hormone oxytocin. Oxytocin is associated with love, attachment and bonding and is present in mothers and their babies during childbirth and immediately afterwards. It is a hormone that is therefore associated with feelings of safety and well-being in relationships. Oxytocin works in conjunction with other hormones, particularly vasopressin which maintains healthy states of arousal and excitement. We can consider these two hormones as related to the relational window of tolerance, oxytocin representing the safe state of parasympathetic arousal and vasopressin pushing more towards the edges, the safe emergency. We all have different base levels of natural oxytocin, and the variation in this may account for differing degrees of resilience among our clients as well as for ourselves.

We can use touch in a number of ways in trauma psychotherapy, including to heighten awareness, to offer the client a sense of ownership of their body, to support a postural realignment or to bring comfort. Whether or not comforting touch will foreclose on something that might be felt or worked through more fully is contingent on the client's level of arousal in the moment, and the intervention needs to be assessed accordingly. Those clients who have experienced traumatic physical injury or violation urgently need to learn the difference between healthy and dangerous touch, and this can help to separate past from present. They also need to be able to determine when to say 'yes' or 'no' or 'not now'. The use of self-touch by clients in therapy sessions is accepted by some as a sort of compromise position. For example, an experiment with skin boundaries and containment might involve inviting the client to use their own hands to mindfully hold or rub their limbs or body surfaces.

Touch is a communication between therapist and client, expanding the capacity for contact (Kepner [1987] 1999: 76). It can be offered as an experiment, creating an opportunity for reflective and pre-reflective dialogue. Kepner points out that from a Gestalt perspective the goal of touch is 'what is *experienced* by the person being touched, rather than the production of some predetermined change' (Kepner [1987] 1999: 77, original italics). It should be added that the therapist's phenomenology and feedback are also valid in the dialogue. Finally and importantly, touch is a vehicle which increases the client's experiential range, learning to make choices about what is liked and helpful and what is not.

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Special considerations in tolerating relationship

The window of tolerance model challenges fixed gestalts about trauma and confounds creative adjustments by demonstrating the price at which they have been earned. Particularly for clients whose experience has included severe relational traumas, the availability of the longed for but feared tolerance of relationship may also be a cause of intense distress and grief. Casement calls this the pain of contrast, sometimes misconstrued as resistance to receiving positive experiences in therapy. This pain 'exposes the depth of early deprivation or the true nature of damaging experience in childhood', and is experienced as an acute shock (1990: 106). The pain of contrast brings the client's wounds directly into the therapeutic space.

For other reasons related often to the traumatic circumstances, some trauma clients hold kindness in great suspicion. Coercion by means of charm, kindly attention or generosity – which is commonly interpreted as grooming – may set the stage for mistrust of the therapist's kindness and compassion. The version of conditionality which rests upon giving something back similarly configures the relational possibilities in therapy. It is for the therapist to decide whether to make these dilemmas explicit, bearing in mind that in so doing the shared mindful field will be disrupted.

A limitation of the Window of Tolerance Model can be seen in the following example. A particularly shame-prone client found my prompting to 'drop' disturbing images and return to her sense of a safe place to be an indication that she was doing something wrong. She had assumed that she had to try and conform to what she understood to be an 'ideal' state that I expected her to attain. Partly, my error was to be too enthusiastic in applying the model, but I additionally failed to appreciate that she wasn't able yet to access resources. Her shame and anxiety triggered a fearful state that needed acutely fine attention. I offered myself as a resource, by accompanying her differently into her regressive and traumatized states.

It was not yet possible to call this client out of her trauma, but instead to bring my more resourced presence into it. I would come to sit close by her, offering her either a blanket or a cushion, having a box of tissues and a glass of water, and some essential oil close to hand. I stroked the back of her hand with the corner of the blanket, placed oil on a tissue for her to smell, as I told her what I could feel of her fear of being hurt again, of the small and secret place she had taken herself into, of her terror, and of how I resonated with these.

I used my body as a regulator, my breath, my timing, my energy field, my temperature, imagining that my client could be aware of these even without the use of direct touch. Communication was body to body. Listening with my body I sensed into what each next step might be,

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informed by what area of her experience seemed figural; this required a reliance on my ability to resonate coupled with my client's subtle energetic communications. The pace of this phase of our work was agonizingly slow, needing to be reworked over many subsequent sessions.

Summary

Forming a relationship with trauma clients can be extremely complex work especially when they have been wounded relationally. The relational themes of their lives need to be understood within the therapeutic context, where they replay on an implicit level, the level at which much trauma is held. Non-verbal features of relating and connecting therefore play a significant part in establishing and maintaining the therapeutic alliance. Included in this are the ways in which we resonate energetically with others as a form of communication, and the part that this can play in the development of a mindful relational field. Within such a field, the trauma can be shared and reflected upon together, and a process of mutual regulation develops incrementally. The window of tolerance can be understood as a relational model for the intersubjective process and for the co-creation of the relationship.

Trauma narratives come into the therapy setting as fragments of largely speechless terror. Alexithymia, the inability to differentiate sensations and emotions and to make neither sense nor use of them, is common in trauma clients; they cannot tell a coherent story that will connect them to us or to the world. Neurologically, the part of the cortex that is responsible for language, called Broca's area, is less active during reminders of trauma. This has significant implications for working with trauma clients, and directs therapists to interventions which start with the body. Creating narratives that describe the client's observable body process is a form of reflective dialogue with the body, as is the thoughtful use of touch, increasing awareness and the integrative possibility of language. The work is kept close to the client's phenomenology as well as the therapist's, building a containing relational space which confirms their experience and strengthens self-functions.

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13 Transforming relational wounds

Because of its hologrammatic and recursive nature, Kepner's model takes into account the breaking through of the traumatic memories in the form of implicit memory at any stage of therapy. Almost inevitably the trauma will emerge spontaneously within the therapy, either by means of a rupture or a relational enactment closely resembling a previous unfinished and traumatic situation. In this chapter these dynamics are explored and discussed, arguing that for clients with early and complex trauma histories they are actually a necessary part of working through the trauma. Ruptures are placed in the context of disorganized attachment, and the dysregulation that they cause is applied to the relational window of tolerance. Different approaches to processing trauma are also considered. To put this into context the chapter opens with a consideration of the often disrupted attachment processes that accompany trauma. We close by considering what it means for a trauma client to become more integrated during the course of therapy, and return finally to Eve's story.

> I will take my sadness and as I can I will make it sing.
>
> (Sheldon Kopp 1972: 159)

Disorganized attachment and complex trauma

Attachment difficulties tend to go hand in hand with the debilitating effects of trauma. Developmental trauma (sometimes termed relational trauma) is always part of what shapes early attachment patterns (including 'secure attachment'), which in turn establish what Bowlby called 'internal working models'. 'The internal working models include procedural memories which organize the core self and its relative degree of vulnerability to destabilisation' (Bromberg 2011: 99). Thus '[i]t is through an understanding of attachment disorders that we can most easily make sense of findings

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related to simple and complex or developmental post traumatic stress disorder' (de Zulueta 2008: 61).

Clinical experience suggests that recovery from trauma at any age depends to a large extent on the availability of one or more secure key attachment relationships. Sadly, significant traumas which occur during adult life often have a knock-on effect to those closest to the victim, who because of their own shock, distress and lack of understanding are unable to provide the necessary regulating milieu for recovery. Furthermore, where early developmental traumas have been significant, in later life the individual becomes more sensitized to interpreting subsequent experience as actual or impending repetition of the original trauma (Stolorow 2007: 11). It is these repeating attachment patterns that distinguish complex trauma from PTSD.

The style known as disorganized or type 'D' attachment can be seen in clients whose parents were experienced as frightening or frightened or were themselves disoriented and dysregulated, and is associated with abuse and neglect, sometimes across generations in families. Disorganized attachment can resemble the phenomenology of dissociation (Schore 2007, cited in Bromberg 2011: 28). Clinically, we notice disorganized attachment in adults with incoherent life stories and abrupt shifts in states of mind, suggesting that trauma is unresolved (Siegel 1999: 110). Three further features of disorganized attachment, according to Hughes, are an inability to rely on self or others in any consistent way; unpredictability in responding to stress; and attempts to rigidly control the events in their lives in order to create some sense of safety (2009: 11). In addition it is almost synonymous with pathologizing diagnoses such as borderline personality disorder, dissociative identity disorder, and sometimes bi-polar disorder. Countering this typology robustly, Stolorow comments: 'To attribute the affective chaos or schizoid withdrawal of patients who were abused as children to "fantasy" or to "borderline personality organization" is tantamount to blaming the victim and, in doing so, reproduces features of the original trauma' (2007: 11).

Disorganized attachment can be held against its polarity of secure attachment, that safe base which allows for growth, differentiation, integration and connection. Many contemporary writers make the link between secure attachment and emotional regulation (see Siegel 1999, 2007; Beebe and Lachman 2002; Schore 2003a, 2003b; Gerhart 2004; Wilkinson 2010). Disorganized clients tend to feel very unsafe both internally and in relation to the field; a central tenet of Chapter 6 was that safety must be the foundation of recovery. It was proposed that the initial therapeutic alliance be formed around attention to safety, and that this is the precursor to establishing experiential relational safety. 'Attunement to your patient's safety . . . must be experienced from *within* the relationship, rather than by trying

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to emphatically "provide" it as a technical stance' (Bromberg 2006: 141, original italics). 'Security is not a feature of the [individual], but rather it describes the nature of an interpersonal connection' (Siegel 2012: 20-6) in which both parties play a part. Trauma therapy is not quick work; having 'long experience of consistency and continuity in therapy becomes a route to a more coherent internal relationship [between dissociated parts]' (Richardson 2008: 71), a sense of integrated connection between self-states.

It is *unresolved* trauma, rather than trauma itself that signals disorganized attachment (Siegel 1999: 111). Hughes observes that while attachment patterns tend to be stable they do not have to be rigid (2009: 58). This gives rise to hope, then, that in the relative safety of the therapeutic relationship, traumas and losses can be resolved and attachment patterns reconstructed. Being part of a therapeutic dyad will inevitably 'reactivat[e] attachment needs and developmental strivings' (Richardson 2008: 67), and it is in this context that the pain of rupture can be felt, perhaps for the first time, and become available for healing.

Rupture and repair in trauma therapy

It may not be going too far to suggest that the effectiveness of therapy is contingent upon the success of the interactive repair process after ruptures, and the new understanding that can arise from it. This process involves the loosening of fixed relational gestalts, some attenuation of unfinished business, and experience in the dialogic dimension of open communication. Lest it be presumed that therapeutic ruptures are problems to be solved, it is important to stress at the outset that ruptures are inevitable, necessary and, handled skilfully, potentially healing. In order to learn to regulate the relationship it is necessary to have something to regulate, and ruptures represent relational opportunities to do so. They are the relational correlates of internal ANS arousal. There is no one way of managing ruptures, and there is a skill in being able to assess what to do about them, resting in part on intuitively understanding the meaning a client might make of them.

A rupture may be something as small as a moment of asynchrony between therapist and client, for example, talking over them. To a client with a traumatic relational history, this might variously be interpreted as a violation of personal space, as a sign of the therapist's disconfirmation, as reinforcing that they cannot make themselves heard, or trigger them into flashbacks of parental discord. Being in relationship with an 'other' is truly experientially threatening. For Bromberg, 'genuine mutuality brings noisiness . . . any experience of disjunction between subjectivities that raises the level of affective disharmony' (2011: 106).

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Clinical vignette

My previous client had used the last tissue in the box. A replacement was ready on the shelf, but I had neglected to open it and place it within reach of my next client. This happened to be someone who was very startled if I made an unannounced movement, especially in dissociative moments when she was less able to distinguish current reality. When she became tearful and looked around for a tissue, my embarrassment at having forgotten the box caused me to leave my seat quickly and fetch it. Stunned, my client said, 'You frighten me', and I could viscerally feel the session being sucked into a vortex. Of course my embarrassment was invited by knowing my client's vulnerability to misattunement; the trap was set and we dropped right into it.

Dysregulation and the window of tolerance

We can use this example as the basis for thinking about the relationship between the window of tolerance and mutual *dysregulation*. In the previous chapter, the Window of Tolerance Model was presented as a relational dynamic, with the space of optimal arousal being co-created through mutual regulation. By the same token, moments of dysregulation, leading to either hyperarousal, hypoarousal or both, are co-created (see Figure 13.1). This is not to suggest that all moments of dysregulation within the therapy setting can be described as ruptures, but simply that the relationship is not yet sufficiently aligned for reliable regulation.

However, the degree to which either individual is responsible is variable, and to some extent irrelevant. So long as the therapist is able to recognize that they do have a part in dysregulation, the regulation will proceed without risk of victim blaming. 'If the patient goes away from a session feeling bad about him- or herself, attributing negative thoughts or feelings to the therapist, this is an event in which the therapist plays a part' (Yontef 2005: 94). The emotions evoked by a rupture can be intense, including anger, fear, sadness, hurt and shame – for either party. There is a risk of escalating arousal if these are not recognized and reflected on together (Hughes 2009: 158).

Ruptures are a specifically relational kind of dysregulating or triggering event, and the repair process is also mutually regulated (Tronick 1998), both parties needing to engage in the recovery. 'Embedded within the patient's often vociferous communication of the dysregulated state is also a definite, yet seemingly inaudible, urgent appeal for interactive

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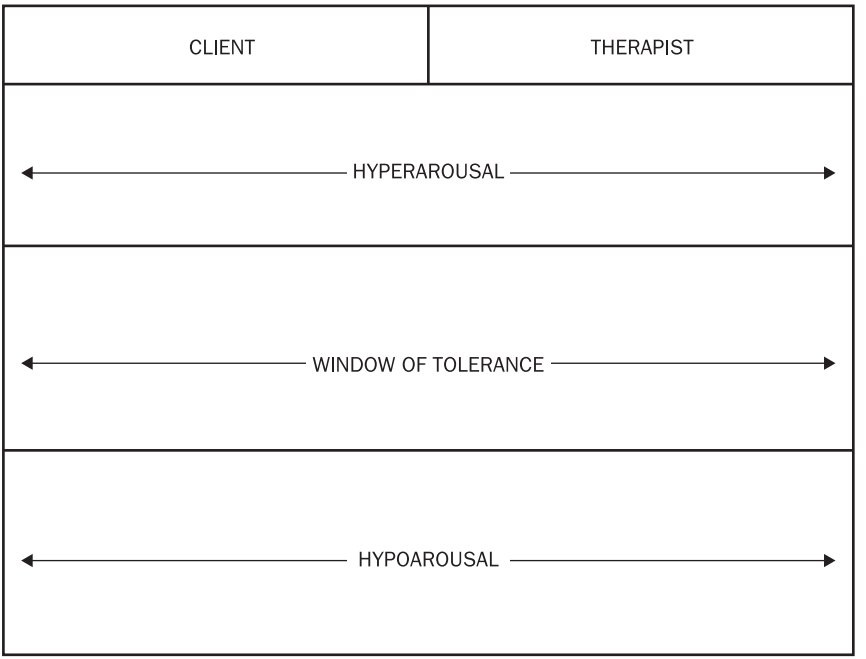

Figure 13.1 Mutual dysregulation

regulation' (Schore 2003b: 92). When ruptures arise there is a caveat to be borne in mind, though, because the repair process may itself be overstimulating. It can come to represent the intrusion of the therapist in wanting to re-establish connection, when the client may prefer to withdraw a little in order to regulate (Siegel 1999: 116).

Any kind of open communication, as necessitated by repair, risks an intimacy that is potentially overwhelming. As Jacobs points out: 'Openness to dialogue ... becomes increasingly difficult as situations are more emotionally charged, and are all but impossible when one has been triggered into a traumatised state of mind' (2012: 65). Trauma victims have already experienced the catastrophic effects of massive disruption of the boundary between self and other and will naturally find it difficult to stay present, especially when the potential conflict involves someone they depend on (Bromberg 2011: 82). Until the relational bond is strong enough, it may simply be enough to acknowledge the rupture non-defensively, apologize for your part in it and seek a stabilizing resource in the moment. The important factor is the therapist's ongoing willingness to initiate

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repair of perceived disruptions (Sapriel: 110), guided by the client's capacity to tolerate it.

Surviving ruptures

The fact that a therapeutic relationship can survive the ruptures along the way makes both therapy and trauma more tolerable. 'The internalization of the relational bond is strengthened rather than disrupted by having to deal with an absence of perfect harmony, *provided the disharmony is reparable*' (Bromberg 2011: 107, my italics). The relationship can now withstand stress. 'Paradoxically, real security is only discovered when the therapist has "failed" the patient but, unlike the past traumatising object, is able to empathically attend and respond to the patient's distress' (Harding 2009: 71). The therapist needs to have confidence that the client and the relationship can recover (p. 27). Trauma clients are often highly sensitive to state shifts in others, constantly checking if they are safe with you *in this moment*. For example, a rupture occurred with one client when I used humour unexpectedly. As Soth says: 'We can never be entirely sure whether what we intend as helpful and therapeutic is actually a repetition of the wounding and counter-therapeutic' (2007).

The open communication which is the vehicle for the repair of ruptures is crucial because it helps each party in the dyad make sense of *one another*. The essential relational function of 'mentalization', the capacity to reflect on the experience of self and on the state of mind of the other, is closely related to the quality of attachments (Fonagy et al. 2004: 97). 'Clinically, the most interesting aspect of the intersubjective environment between patient and analyst is the mutual knowing of what is in the other's mind, as it concerns the current nature and state of their relationship' (Boston Change Process Study Group 2010: 7).

Ruptures and their repair involve confrontation with another subjectivity, allowing for increasing differentiation of self. Having said that, 'It is [also] required of the therapist to "decenter" from the structures of his own subjectivity in order to understand those of his patient . . . these elements may have been unnoticed or considered unimportant by us, but can be shown to have enormous significance to the patient' (Brandchaft and Stolorow 1994: 109). Further, to work effectively to resolve these moments, the therapist needs to listen to 'the immediate and residual effects of his own participation' (Bromberg 2001: 151), and the 'intersubjective field in which such behavior takes place should now be equally minutely studied' (Brandchaft and Stolorow 1994: 105), within the shared mindful field. It is by repetition of these processes that the client becomes able to decouple the trauma from the relationship.

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What's going on? Trauma made manifest

In the early stages of therapy, most of the crises that present are those day-to-day disruptive events which the client is as yet unable to negotiate or avoid. Surviving these together, without judgement for the messes the client gets into, prepares the ground for the emergence of crisis within the therapy itself. The therapist acts implicitly as a relational bridge to the trauma. At some point, the therapeutic relationship gets into a mess, and needs to. Soth (2007) describes this evocatively as the wound entering the therapy: 'The wound [of trauma] gets experientially constellated in the therapeutic relationship', and this dynamic is referred to as an enactment. Enactments bring the work to the heart of the client's relational and traumatic wounds, speaking to their most intense, secret and shame-laden fears and longings. For example, a phobia of the therapist (see Chapter 6) with which many trauma clients enter therapy includes a fear of emotional engagement as a defence against their longing for connection, and the therapist may thus be cast into the role of the disengaged other.

However, more than feeling cast in a certain role or otherwise pulled out of shape, an enactment is a situation in which a therapist is drawn, out of awareness, into repeating something of significance to the client. According to Philippson, 'the fixed patterns [self-states] rely on others to pick up and take on their parts in the interactions' (2012: 89). Thus therapeutic enactments involve both parties in the relationship:

> To insist that when patients feel endangered by a therapist their perceptions of him must be faulty in effect constitutes a 'cordon sanitaire' around the therapist. It precludes the unhampered investigation of the patient's subjective reality, so that the persecutory experiences can be understood in greater depth, including the therapist's unwitting contribution to them.
>
> (Brandchaft and Stolorow 1994: 98)

In Kepner's model, enactments of this nature come under the umbrella of 'undoing'. He says this involves 'placing back into the interpersonal field those things now experienced as part of the self that were originally part of the interpersonal world but never experienced as such' (1995: 110), the 'placing back' happening out of awareness. Ultimately transformative, the pair first need to 'hang around' in, and live through, the mess (Bromberg 2011).

A central tenet of Bromberg's writing (2001; 2006; 2011) is that during an enactment the therapy enters *a co-created dyadic dissociative process*, creating a shift from shared mindful states to shared dissociative states.

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Dyadic dissociation seems to be the hallmark of an enactment, for if both parties were aware of what was going on there would be nothing to enact. This process 'drains the interpersonal context of meaning. By unlinking the mind from the reflective perception of dyadic affective experience, a person is isolated from the danger of directly experiencing an other's "otherness"' (Bromberg 2011: 52). Neither therapist nor client is fully open to contact within the shared reflective space, although either one may think they are. For a time, the relationship comes under enormous pressure.

Bromberg usefully describes the phenomenology of the therapist's dissociation:

> For a period of time he loses his bearings and is not able to think clearly about what he is experiencing. He cannot even find what appears to be a useful way of engaging with his patient in the here and now because his patient's mind is feeling so unfamiliar. He then dissociates, which leads to his disconnecting affectively from his patient and turning inward to the library of his mind where he can at least rummage around for some almost new ideas that might even be true. Is this bad therapy? Only if the analyst is content to be relationally unawake for too long.
>
> (2011: 110)

Eventually the dreaming therapist must awaken (Bromberg 2006), and the shared mindful and regulating field is restored. This then creates an opportunity to understand 'how the client experiences the therapy, and the therapist, *through* their character, *through* their wounding' (Soth and Eichorn 2012: 15, original italics). There is an inherent paradox in these enactments, as Soth describes (2007), in which the seemingly counter-therapeutic enactment and its transformation are actually two sides of the same coin. Stolorow, writing of his own experience of trauma, puts it beautifully: 'When my traumatized states could not find a relational home, I became deadened, and my world became dulled. When such a home became once again present, I came alive, and the vividness of my world returned' (2007: 26).

Clinical vignette

For the first year or more of our work together, I was able to use my knowledge of trauma to manage my own anxieties about being with Jocelyn. However, I became increasingly and irrationally concerned about her lack of relationality with me; she invariably turned away from me; she neither greeted me nor thanked me nor said goodbye at

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the end. Our relationship was often conflictual, the collision of subjectivities, but she seemed unable to hear of my side of it, even after these months of therapy. I could not recognize myself in her descriptions of me. Jocelyn seemed to want to know who I was and yet when I offered her more of myself she rejected me. If I showed her my felt response she thought I had too many issues of my own, and if I didn't I became uninvolved. This process was more intense and troubled me more than with other similar clients; it was something particular to Jocelyn and me. There were times when I felt as though she was playing mind games with me. It was all my fault and I duly felt that I was doing a bad job with Jocelyn. I was lost in wanting to increase contact with her, and became preoccupied with thoughts of needing to be seen as a human being by her.

It so happened that I needed to cancel a session at short notice because my frail elderly mother-in-law was rushed into hospital. I took it as an opportunity to show myself as a human being, and told Jocelyn the real reason for my cancellation instead of cloaking it in something vague. Her response was that she hadn't wanted to come today anyway, which when I reflected later, pulled me up short. When she did not arrive for her next session I finally woke up, and consulted my supervisor. Jocelyn's relational history included chronic sexual abuse by her womanizing father, a man of dark charm, and a mother who was mentally unwell, in and out of hospital, always needy and manipulative. Her mother, when she was not in thrall to her illness, repeatedly contradicted Jocelyn's subjectivity – 'You don't think that, you think this' being the flavour of these interactions. Little wonder, then, that Jocelyn's attachment style was so disorganized.

With the support of my supervisor I was able to decentre my preoccupation with Jocelyn's recognition of me, in order to recentre my recognition in her experiential world. My supervisor's challenge was 'Why shouldn't she spend the whole session with her back to you if she wants?' At the beginning of our next session, Jocelyn made eye contact with me, a serious, pained expression in her that moved me into feeling her distress, a small and almost miraculous reorganization of the relational field as a result of the question my supervisor had asked. Jocelyn seemed to be taking me in through her eyes, as I saw into her loss and longing for connection. She had been through such a difficult time recently, but began to speak of it from a more integrated and resourced state. My implicit recognition of the intrusions and neglect of Jocelyn's early years, and my access to the effects of shame, objectification, separation, denial and dissociation now gave us a 'shared' history. Our contact became more potent and vibrant thereafter.

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Acts of triumph

Working through enactments provides the opportunity to make implicit levels of communication explicit, and reorganize somatic creative adjustments. Trauma manifests itself not only through relational enactments but through the multiple and subtle ways in which the 'body keeps the score'. Just as earlier the notion of unresolved attachments was mentioned, the trauma, held in the body, remains for some considerable time unresolved or unprocessed. The body has unfinished business.

Kepner's account of the third stage of therapy, undoing, redoing and mourning, which this resolution correlates to, includes a comment that abreaction for the sake of it should be avoided (1995: 113). He argues, however, that in order to experience him- or herself differently, the trauma client *may* need to engage in large, noisy and energetic expressive experiments, cautioning that the *'drama should be congruent with the readiness of the client to integrate the drama as a part of the evolving self'* (p. 114 my italics). It is helpful to recall here that recursive trauma responses are the result of overstimulation and a mass of stressful material that cannot be integrated by the nervous system of the victim. Criticisms of Kepner's thinking are therefore that these expressive experiments do not necessarily address the trauma but rather the effects of the trauma; they do not necessarily increase the client's control over or awareness of the trauma in the body; they do not necessarily reorganize the somatic experience of the client and they do not necessarily allow for slow and calibrated integration of the new experience. These criticisms should not suggest that there is no place for the release of expressive experiments, either.

Compare this to the Sensorimotor approach, in which 'slivers' of traumatic memory are reactivated at the edges of the window of tolerance – equivalent to the safe emergency of Gestalt therapy. These slivers can then be processed through the body, returning again and again to the resources available (Ogden et al. 2006: 243). This is achieved through phenomenological tracking, based on the client's increased ability to disengage from the content and meaning of the trauma, and instead attend mindfully to the physical components of the experience as they arise. This helps to uncouple the linkage between traumatically generated associations experienced somatically. It is interesting to note that the oscillation between traumatically charged material and resourced states resembles the rhythm of EMDR (Shapiro 1995), the 'technological' approach to trauma processing, in which successive periods of arousal associated with 'target' memories are triggered by bi-lateral stimulation and followed by periods of quiet and reflection.

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We can imagine that this oscillation supports the integration of the brain, strengthening linkages between limbically mediated charge and the cortex.

The intention behind the processing of fragments of memory through the body relates to the theory of immobilized defences (Chapter 7), and the need to complete those defences that were truncated or aborted at the time the trauma took place (Levine 1997): 'It is a basic tendency of the organism to complete any situation or transaction which for it is unfinished' (Perls et al. [1951] 1998: 77). Where trauma has interfered with and delayed this natural process, sufficient resources provide the ground for its restoration. '"When the implicit (procedural) memory is activated and completed somatically, an explicit narrative can be constructed; not the other way round"' (Levine, P.A., cited in Ogden et al. 2006: 248). Ogden et al. describe this active completion as the execution of 'acts of triumph' over the trauma (2006).

From the frozen or collapsed position of the immobilization, the client needs to find actions which will support the completion of the defence – pushing, turning, kicking, running. These may be very small but significant reorganizations of the range of choice available to the client. By tracking sensations as they arise and fall in the body, the client is encouraged to identify the emergence of impulses to move, and to allow that movement to take place, honouring the fact that the body knows what it needs to do. This translates in Gestalt language to the undoing of inhibited or retroflected somatic impulses. Voluntary movements certainly play a part in this but so do emerging involuntary movements. It requires an enormous amount of control over the body to trust in the possibility of surrendering to involuntary processes, especially those associated with trauma. However, this is necessary because it pertains to unresolved autonomic arousal, orienting and defensive reactions (Ogden et al. 2006: 253).

These writers also suggest searching for 'peritraumatic' resources, those maybe even counter-intuitive instinctual defences that were available at the time of the trauma (Ogden et al. 2006: 244). One client had witnessed a bloody scene of domestic violence as a young child, and remembered that he had closed his eyes at the horror of it. This minute action, the only one possible in the extreme danger of the moment, felt enormously powerful to him, and gave rise to hope that he could follow through and release the residual trauma. By encouraging him to repeat this symbolic looking away from the scene before him, the client was enabled to mindfully access a sequence of impulses, interspersed with moments of present orientation, that incrementally turned first his eyes and head, and then his whole body in the opposite direction, one in which he was free to walk away.

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Reflection point

Consider some aspect of unfinished business in your own life. What is needed to help you find some resolution? Is there a need for interactive repair of some sort, or for you to reclaim a defensive function that for some reason has been denied you thus far? What needs to be communicated that has yet to be confirmed in the context of a relationship? And what does your body need to do to release the fixed patterns? Write for some minutes about your situation and your response to these questions.

Integration, narrative and earned attachment

The healing of splits with which we started, and have explored through the lens of the dissociation between traumatized self and the historical traumatizing field, is, as we have seen, a complex task. The many facets of trauma are embraced: the implicit, making it explicit; the discontinuous, making it continuous; the disembodied, making it embodied; the timeless, making it present; the uncontainable, making it containable; the fragmented, making it coherent. The challenge of integration happens at multiple levels, including emotional, verbal, neural, narrative, cognitive and sensorimotor (Siegel 1999; Ogden et al. 2006: 300); exclusion of any one of these modes of being would by definition not be fully integrative. From the discussion in Chapter 2 on change, integration and healing, to hints earlier in this chapter and elsewhere throughout this volume, we come to see that both unresolved trauma and attachment issues can, through relational trauma focused therapy, be resolved and the splits restored. As Boadella says, '[t]herapy is a journey towards the joining of what was split, the coupling of broken images' (1987: 123).

What then, do we mean by integration at this stage of the therapeutic journey? We revisit Siegel's important contribution to the understanding of integration in psychotherapy. At its most simple is his definition of the linkage of differentiated parts (2009: 165), the polarity to dissociation, and as such a fundamental dimension of health (2012: 16-1). Integration might therefore be seen as a desirable outcome of trauma therapy. Siegel states that: 'The maintenance of the differentiated qualities of the individual components of the system even while linking them is an essential aspect of integration' (2012: 16-4). A feature of such linkage is thus that the 'whole is greater than the sum of the parts', speaking to the values of Gestalt therapy (pp. 16-4). Beyond his rather technical description, however, for

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Siegel integration is a process that creates coherence in the mind (1999: 321). In his inimitable style, he uses the word 'coherence' as an acrostic: *c*onnected, *o*pen, *h*armonious, *e*ngaged, *r*eceptive, *e*mergent, *n*oetic (a sense of knowing), *c*ompassionate and *e*mpathic (2012: 16-5). After the confusion and messiness of trauma, we have arrived at a point of clarity where the mud can settle. This concept of coherence has relevance to attachment, trauma, memory and self.

One of several interlinked areas that Siegel is interested in is that of attachment. He contends that it is possible for attachment wounds to be healed, via the emergence of 'earned' autonomous attachment for adults (2007: 201). For Hughes also, attachment security can be attained, while at the same time the adult is able to function autonomously (2009: 56). Siegel suggests further that the creation in therapy of a coherent narrative of self, even though it will necessarily be a painful one, is the organizing factor in earned attachment. The original trauma narrative has been reorganized to include new, realistic and more consistent perspectives on identity, self and other. In similar vein, Wilkinson argues that 'an emphasis on *coconstructing* narrative may play a vital part in assisting the patient not only in coming to terms with the reality of his or her internal world, but also in the process of mourning what was and what might have been, which then enables a greater capacity to live life as it is now in the real world' (2010: 133, my italics).

Narrative gives the trauma client authorship of their life, allowing them to adopt 'different perspectives on or versions of the experience of self' (Siegel 1999: 324), where previously the sense of power was placed in the field. Coherence of narrative may actually be what constitutes self, or rather having a sense of self, that is compatible with the Gestalt therapy understanding of self in process, in contrast to self being something more fixed. At the heart of this is being able to 'make sense' of their life, which in turn can alter their 'attachment status' as adults, including the possibility of raising children who thrive (Siegel 1999: 204). Through mindfulness the adult trauma victim is able to reflect on their relationships with others, communicate openly, empathize and repair ruptures.

The unfinished business of trauma can never be truly finished; trauma brands its imprint into the very fibres of its victim's being, and is at the heart of their narrative. But the trauma victim emerges from therapy into a different field, by virtue of the fact that they have changed and will continue to change. As Siegel says: 'Creating coherence is a lifetime project. Integration is thus a process, not a final accomplishment. It is a verb, not a noun' (1999: 336). Trauma clients continue to create their own fields of reciprocal influence throughout their lives and thus the ripples of our work may spread far.

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Case Study Part 5

After a particularly difficult stage in her therapy, when Eve and I worked through a significant rupture, she realized that she could no longer stay in her job because of the harmful impact it was continuing to have on her. These are her words: 'I told him what I want, didn't get caught in "shoulds" and "oughts", just told it straight . . . it was a relief actually. I feel like I can see better, it's not about being strangled by it but about having more range. It releases something, I'm out of there.'

Despite her financial insecurity, Eve was able to tell herself that she had already survived something far worse than this and that she and Freya would manage somehow. They moved into a smaller and cheaper flat, nearer to school so that Eve did not have to pay bus fares. Eve found she didn't miss the space of her larger flat, saying that she had more sense of space inside her and new possibilities were opening up. Eve felt safer inside and more in control of her life. She was vulnerable to setbacks, particularly when her mother had cancer treatment and she didn't find it easy to set limits on the help she offered.

Eve said the thing that made the most difference to her was my patience and calm, and my honesty and openness helped her gain trust in me. She felt understood by me, which grew from how I confidently conveyed my understanding of trauma.

Eve's therapy came to an end more quickly than she had planned because she had run out of money. We continued to meet less frequently for a few months, and Eve learnt to rely on herself to manage triggers and her reactions. However, there was still some work that we were not able to address, and her phobia of pain remained, as did the occasional temptation to self-harm, which when I last saw her she was not acting on.

Summary

Our ways of being in relationships with others tend to reflect the dynamics of our early upbringing, and this has a connection with the development of disorganized attachment. Associated with complex trauma, disorganized attachment arises from the experience of being raised by caretakers who were either frightened or frightening or themselves disorganized; an absence of safety is definitive of this relational tendency. It is an explanation for the transmission of trauma between generations in a family. This attachment style brings with it particular sensitivities which come to be enacted one way or another in the therapeutic relationship.

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First, ruptures are an inevitable part of therapy, and have particular implications for working with trauma clients and in reconfiguring the disorganized relational ground on which they stand. For some, ruptures signal conflict and are thus minimized as a regulatory manoeuvre. For others the dialogic attitude of paying close attention to the relational dynamics of ruptures requires an intimacy which is extremely anxiety provoking. Either way, for the client therapeutic ruptures can be experienced as a threat to a relationship upon which they depend. They have yet to discover the therapeutic value of restoring relationships that have gone off track.

A further way in which therapeutic relationships get into difficulty is when the relational wounds of the client are replicated in the here-and-now. These enactments happen out of awareness; a co-created dissociative process, according to Bromberg. Both parties become disoriented to the relational context and to the subjectivity of the other. However frightening and painful these episodes may be, they are necessary in order to make explicit that which has previously been dissociated from the client's awareness. The therapist has taken on a part which feels familiar to the client, creating what can be seen as a shared history, deepening understanding and enabling transformative shifts once the therapist has 'woken' from the dream state.

In so far as the body has been implicated in the trauma, it also needs to be released from the body. Expressive techniques of classical Gestalt therapy can be used within the client's capacity to tolerate them, but shuttling between activated slivers of memory at the margins of an expanded window of tolerance and more resourced states holds the potential of integrating the processing of trauma to a more resolved outcome. The integrative capacity of the body is one mode among several others, of accessing a more coherent sense of self, a narrative that includes different perspectives and the possibility of reaching 'earned' autonomous attachment as an adult.

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Glossary

In addition to the terms defined below, readers unfamiliar with Gestalt concepts are recommended to turn to an excellent small book, *Gestalt Therapy: 100 Key Points and Techniques* by Dave Mann.

aggression The ability to act as agent in the world, to get one's needs met, to make contact.

assimilation A stage on the cycle of experience following contact, as the figure recedes, before the new figure emerges. It is a stage of integration of contact and novelty necessary before a new figure emerges.

awareness Related to **phenomenology** and **figure** formation, awareness is turning attention to something, often the perception of a sense, a moment of contact, patterns or emerging excitement.

awareness continuum The ongoing sequence of unrepeatable aware moments. The sense that one thing follows another, that the experience of life is not fixed but fluid and in constant process.

body; body/mind Body is inseparable from self. We exist not only through our thoughts, language and intention, but also through action, sensation and feeling. Body is a medium for contact, and expresses our way of being in the world. Gestalt works with the whole self, not simply the contents of thoughts and beliefs. The body is valued for its integrative potential; seen as the seat of inherent wisdom and authenticity. There is a reciprocal feedback loop between the trunk, limbs and organs of the body and the brain. Body and mind are reflections of one another. It is in this sense that body/mind is used; the mind is not confined to the brain as organ.

confluence A modification to contact whereby the boundary between self and other is not distinguished and becomes blurred or merged.

contact Contact is not the same as togetherness or joining, rather it is the meeting of difference. Contact and withdrawal are two sides of a coin; withdrawal is contactful in a limited way. We cannot be in contact with the total field at any one time. Contact is the most active process on the cycle of experience, involving a combination of sensing, energetic engagement, and inclination towards the other/environment. Gestalt therapists are interested in the quality and style of contact. The ability to make good contact is one way Gestalt therapists understand psychological health, as fluid, satisfying and receptive to novelty to support growth.

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contact boundary The point in space and time where meeting occurs. In Gestalt **self** emerges in contact with the other at the boundary. The boundary can be disturbed *by an individual* in a number of ways, modifying contact. This has important implications for understanding reactions to trauma, in which there is a devastating reorganization of the boundary between self and other.

contact functions These are elements of behaviour, usually observable, by which an individual reaches into the environment in order to support contact. They are differently available and developed in every individual. They include: movement, voice, seeing, hearing, feelings and bodily process (Joyce and Sills 2010: 59).

contact style The **phenomenology** of contact processes.

creative adjustment Responses to the demands of the other or of the environment in the best way available to ensure ongoing survival, regulation and relationship. Sometimes creative adjustments are compromises, especially when made at some disadvantage, such as those made early in life and in the face of powerful others.

creative indifference A relational position associated with the **Paradoxical Theory of Change**. The therapeutic creative stance of not being attached or invested in any particular outcome for the client, which according to the **phenomenological** approach is for the client to define.

cycle of experience Concerned with the formation of **figures**. The cycle, often illustrated as a wave, involves the following stages: sensation, awareness, mobilization, action, contact, satisfaction, assimilation and withdrawal. The figure arises from a ground known as the fertile void.

desensitization A **modification to contact** diminishing awareness of sensation at the beginning stage of figure formation. Desensitization can be seen in those removed from embodied life, sometimes to the extent of numbing or deadening.

dialogue One of the three pillars of Gestalt therapy, which reaches beyond everyday conversation, focusing on deep meeting, verbally and non-verbally between people. Dialogue incorporates Buber's I-Thou and I-It of relatedness. For Gestalt therapists, relationship is co-created and emphasizes a dialogic attitude, aware of and open to the humanity of the other. Buber's four principles of dialogue are presence, confirmation, open communication and inclusion. Inclusion is similar to but uniquely different from empathy. It means leaning into the world of the other without losing one's own subjectivity.

egotism A **modification to contact**, which limits contact by self-criticism, over-analysing and preoccupation with how one comes across. In a healthy sense, it supports reflexivity, self-regulation and self-reflection.

experimentation Allows clients to expand their range of available choices by becoming more fully who they are. Traditional 'staged' Gestalt

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experiments can involve challenge and sometimes confrontation. In contrast, experiments can be quite small, such as trying out 'I' language, or imagining a new behaviour. Experimentation creates the 'safe emergency' whereby the client can rehearse and adjust new ways of being. Experiments arise naturally from the dialogue, are co-created with the client and are calibrated according to the support available, so as not to be exposing or dysregulating. Experiments can develop missing polarities and resources, often by exaggerating or repeating an embodied communication, and can introduce playfulness into therapy.

field One of three pillars of Gestalt theory. The term 'field' in Gestalt is used in reference to different things. The term derives from two sources. First, Gestalt psychology refers to the perceptual field, an individualistic concept. By this interpretation, there can be no shared field. The second meaning is based in Lewin's field theory, and refers to what is sometimes known as the 'lifespace' of an individual, the terms 'environment' and 'situation' also being used interchangeably with field. According to Lewinian theory, the behaviour of the individual is embedded in a context. This is a more integrative frame of reference. For the purposes of this book, we must also emphasize that the fluctuating internal physiological state of the individual is also part of the context to be taken into account. This concept is closely related to that of **self**.

figure What is being attended to now; the dynamic organization of experience. The emergence or formation of a figure is always set against a **ground**, from which it is indivisible and into which it recedes, like the relationship of a wave to water. There may be a number of dominant themes in any life at any one time, only one is the figure which is selected from that ground in any one moment.

fixed gestalt A process whereby selfing (see **self**) gets stuck and is less responsive to change and outside influence. It is a rigid pattern repeated continuously in an individual's life, a more structural form of **creative adjustment**. A key concept in understanding trauma, in which responses become embedded and solidified in the structure of contacts, and cannot easily be updated according to current conditions.

gestalt A German word roughly translated as the configuration of something in its entirety. It relates to the holistic stance of Gestalt and to the need to complete inherent in the concept of unfinished business, key for trauma therapy.

ground An undifferentiated condition containing aspects of the field, historical and contemporary. It also consists of traces of experience and physiology which provide a context to the perception of the figure. A healthy relationship between figure and ground is always dynamic. Ground and **field** are not the same.

inclusion See **Dialogue**.

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mobilization A stage in the development of a figure in which energy is gathered in the interests of making good contact.

modification to contact The temporary or fixed adjustment to contacting according the current or historical **field**.

organismic self-regulation The biological organism's innate ability to return to a state of balance after disturbance. It is based on the principle that the body is able to restore itself to healthy functioning, seriously compromised in trauma.

Paradoxical Theory of Change A philosophical foundation of Gestalt therapy, Beisser's theory of change. This states that change occurs not when one tries to be different, but when one is able to be fully who one is. The theory informs and underpins much of the process and relational position of Gestalt therapy.

phenomenology One of the pillars of Gestalt therapy, which places emphasis on the study of the subjective experience of the client as they perceive and make sense of their world. It involves observation of experience and perception by both client and therapist, privileged over interpretive approaches. Phenomenology is interested in sensation as the basis of felt experience, an entry to embodiment. Phenomenology can be described as being 'experience-near'. The client comes to make their own meaning of experience.

polarities Dynamic and opposing properties, both of which need to be supported to achieve a state of equilibrium and form a complete gestalt. Such properties may be disowned or separated through denial of one pole while the other is more emphasized. Working therapeutically with polarities seeks to establish the 'middle ground'. The middle ground can be represented by a range of possibilities on a continuum between the poles.

retroflection The **modification to contact** of turning towards oneself, as opposed to expressiveness and spontaneity, e.g. holding in anger or sorrow.

response-ability The ability to make fluid and spontaneous responses in the moment rather than stereotyped or habitual ones.

self In Gestalt therapy self is a dynamic emergent process (selfing) rather than the essence of someone or something that is fixed. Self actively organizes and manages experience within the **field**, and is a function of that field. There is ongoing debate in the Gestalt community about the existence of a 'core self'. From a field perspective, self is sometimes referred to as 'organism' though this is more accurately understood as the biological organism.

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Index

Abuse, *see* trauma
Abuser, internalized, *see* shame
Acceptance 149, 153, 156, 160–2
Acts of triumph 228–9
Affective neuroscience, *see* neuroscience
Agency 120, 136
Aggres, aggression, 81–2, 124, 178
Alexithymia, *see also* verbalization 212
Alienation 118, 128, 140, 154, 160, 211
Anger 66, 124, 154, 161, 180, 222
Anxiety 5–6, 33, 91, 95, 98, 196
Appraisal capacity 97, 99, 102–3, 109
Arousal, *see also* excitement 44, 58, 60–6, 93, 114–15, 174–5, 179–80
  Autonomic Nervous System (ANS) 71, 73, 75, 175, 221, 229
  hyperarousal 57, 66, 69, 101, 115, 222
  hypoarousal 64, 69, 75, 115, 135, 180
  moderation of 85, 101, 116
  optimal arousal 63, 84, 210, 222
  parasympathetic arousal 60–1, 69, 86, 114–15, 216
  sympathetic arousal 60–1, 69, 86, 111, 157, 174
Attachment 93, 100, 119, 157–8, 174, 219–20
  disorganized 220–1, 232
  earned 231
  insecure 41
  secure 41, 219–20
Attention 28, 52, 79, 85–7
  concentration 84–5, 104, 121, 143, 145
  focus of 44, 52–3, 63, 79, 111, 217
  shift in 38, 69, 197
Attunement 105, 148, 158, 179, 200, 206
Authenticity, authentic 13, 35, 117, 129, 140, 171
Autonomy, *see also* agency 117, 119–20, 124
Avoidance 27, 91–3, 118, 134, 150
Awareness 12–13, 77–88
  aware body 82
  of awareness 84, 87
  of body 68, 87
  continuum 78
  of current experience 77, 84, 86
  directed, *see also* mindfulness 81, 86, 121, 200
  dual awareness 7
  zones of 76

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Beisser, A. 23–5, 37, 169–71
Belonging, sense of 133, 140, 142, 149, 151, 205
Betrayal 119, 133, 140, 151, 172, 208
Blame
  self-blame, *see also* shame 34, 111, 156
  of victim 153, 164
Body
  awareness of, *see* awareness
  embodiment 13, 66, 82, 96, 129, 190
  as enemy 54
  history held in 113
  impulse 70, 100, 111, 114, 116, 123
  memory 68, 107
  process 13, 34, 65–6, 189, 213
  resonant 196
  structure 46, 11
Body/mind 32, 93, 97, 194, 204, 211
Body structure 46
  adaptive 112
  collapsed 113, 127
  rigid 113–14
Boston Change Process Study Group 25, 182
Boundary 104, 118, 132, 140, 153, 223
  contact 76, 94, 111, 118, 148, 152
  functions 93, 103–4
Bracketing, epoché, *see* phenomenology
Brain 6–10
  amygdala 10, 97–8
  brainstem 28
  cortex 28
  fear circuit 10
  hippocampus 28, 30, 97, 99, 109, 134
  left hemisphere 135
  limbic system 29–30, 86, 138, 174
  neural pathways 28, 53, 98
  right hemisphere 12, 30, 33, 157
  social 210
  thalamus 30, 134
  triune 28–9
Breathing, breath 52, 61, 121, 200, 210, 214
  exhalation 61, 114
  inhalation 61, 114
Bromberg, P. 16, 130, 135, 140, 184, 224–6
Brownell, P. 13, 59, 86

Change
  'bottom up' 24, 34, 54, 86, 103
  Integrated Model of Change 35–6, 80, 82–4, 170
  moments of 25
  Paradoxical Theory of Change 23–4, 35–7, 82, 160–1, 169, 171
  relational aspects of 25–7, 169, 171–3, 179–80, 184, 230
  'top down' 5, 24, 34, 103
  therapist as agent of 25, 169, 180
  theories of 23–7
Chaos 49–52
  edge of chaos 51, 64–5
Choice 119, 154, 161
  field of 51, 53, 119, 229
  reduced 13, 22, 31, 51, 120
Co-creation, co-transference, *see also* transference, 125, 153, 170, 175
Cognitive-Behavioural Therapy (CBT) 4–5, 136
Coherence 33, 40–1, 64, 129, 213, 231
Collapse 93, 100, 110, 114
Compartmentalization, *see* fragmentation
Compassion 36, 85, 112, 154, 161–2, 193
Complexity 50, 65
  complexity theory 49–51

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Concentration 84–5, 104, 143
Confluent, confluence 154, 191, 210
Contact
  boundary, *see* boundary
  functions 48, 94, 130, 175, 192, 210
  style 129
  modification to 129
Containment 36, 52, 79, 104, 178, 216
Control 102, 106, 114, 119–22, 152–3, 171
  and autonomy 26, 120, 132, 203
  involuntary 60–1
  locus of control shift 118, 124, 150
  loss of sense of 8, 24, 75, 110, 116, 220
  restoring sense of 24, 53, 67, 117, 124, 229
  voluntary 12, 112, 122
Core beliefs 166
Corpus callosum 30, 135
Cortex, *see* brain
Cortisol, *see* neurochemicals
Co-transference, *see* co-creation
Cozolino, L. 12, 27, 95–9, 179, 184, 188–9
Creative adjustment 45–6, 68, 112, 132, 136, 149
Creative indifference 171–2
Creativity 2, 23, 45, 103, 117, 214
Crisis 58, 119, 128, 192, 225
  emergence 192, 225
  existential 128, 148
Cycle of experience 42, 58, 81, 111, 115, 210

Danger 9, 61, 91–3, 95, 105, 174
Damasio, A. 97, 134, 188
Defences, defensive reactions, *see also* creative adjustment
  aborted, truncated 70, 99, 103, 125, 136, 229
  attach response 138, 141, 155
  defence mechanisms 99
  fight response 61, 70, 99–100, 111, 138, 162
  flight response 60–1, 70, 99–100, 111, 138, 155
  freeze response 61, 100, 113, 138, 155
  immobilized, passive 100–3, 110–18, 125, 162, 174, 203
  mobilized, active 100, 102, 112, 125, 138, 203
  submit response 138, 155
  survival instinct 28–9, 40, 53–4, 99, 150, 160
Delisle, G. 16, 67, 76, 140, 149, 178
Denial,
  cultural 22, 26, 132–3, 158–9
  self-denial 117–18, 149, 159
Depersonalization, *see* dissociation
Derealization, *see* dissociation
Desensitization 129–30
Dialogue 74, 80, 179–80, 214, 216, 223
  inner 130, 144, 146–7
Differentiation 2, 12–13, 76–7, 106, 179, 213–14
Dissociation 45, 69, 128–45, 151
  co-consciousness
  depersonalization 131
  derealization 131
  desensitization on continuum with 129
  Dissociative Identity Disorder (DID) 220
  dyadic 193, 226–7
  function of 131–2
  healthy or normal 131
  neurobiology of 134
  part selves 135, 175, 221
  somatoform 134
  Structural Dissociation Model, dissociated parts 135–140

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Dialectical Behavioural Therapy (DBT) 5
Domestic Violence, Abuse, *see* trauma

Eating
  disorder 4
  distressed 54, 134, 150
Egotism 80, 184
Embodied self 33, 133, 145, 162, 189, 197
Emergence 43, 53, 158, 229, 231
Empathy 141, 189, 201
Enactment 110, 158, 225–6
Energy, *see also* arousal 42–3, 58, 68–70, 114–16, 130, 180,
  fields 124, 180, 201, 204–5, 208, 217
  qualities of 60, 205
Environment, *see also* other 40–1, 102, 114–15, 140, 149, 224
Ethics 180, 196, 215
Eye-Movement Desensitization and Reprocessing (EMDR) 5, 53, 103, 136, 228
Excitement, *see also* arousal, energy 42, 58, 78, 93, 114, 216
Executive function 50, 59, 134, 138
Experimentation 11, 123, 173, 213, 216
Experiments, for therapists
  embodied, experiential 62, 66–7, 113, 122, 155, 198, 205, 214
  reflective 77, 82, 27 105, 133, 139, 143, 160, 176, 178, 180, 188
Expert position 26, 169–70, 172
Exposure techniques, flooding 5
Expression 66, 111, 123, 135, 155, 212
Explicit memory, *see* memory
Eye contact 155, 175, 210

Failure, sense, of *see* shame
Fear, panic, terror 7, 22, 66, 91–106, 111, 212
  circuits 10, 28, 97–8, 102, 111
  conditioned response 97
  unintegrated 95
Field, *see also* other 59, 112, 129, 142, 148–9, 158–9
  contemporaneous, principle of contemporaneity, *see also* time 31, 77
  current 76, 117
  embodied 189
  familial 132
  historical 140
  legal 1, 159
  political 1, 132
  relational 11–13, 25, 119, 142, 151, 178
  societal 1, 158
Fight or flight, *see* defences
Figure, *see also* ground 41–4, 65, 68, 81, 93, 211
  formation 42–4, 46, 55, 58–9, 78
  trauma 52, 94, 97
Fisher, J. 61, 68, 156, 180
Fixed gestalt, *see* Gestalt
Flashbacks, *see* intrusions
Flexibility, fluidity 27–8, 51, 99, 119, 143, 180
Fluids 60, 94
Fogel, A. 33, 60, 78, 111, 194, 209
Forgiveness 161, 165
Fragmentation 51, 75, 132, 136, 138
  compartmentalization of experience 75
  splitting, *see also* splits 1–2, 13, 32–3, 130, 132, 135

Generalization 50, 76
Gestalt 11–16
  dialogue, *see also* dialogue 25
  empty-chair technique 12
  experimentation, 81
  field theory, *see* field
  fixed 24, 41, 73, 112, 153, 221

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organismic self-regulation, *see* organismic self-regulation
phenomenology, *see also* phenomenology 26
principles of, values 2, 6, 32, 40, 45, 50
relational, *see* relational 119, 140, 208
theory 12, 40, 43, 58, 79, 160
Guilt 151, 153, 157
Grading, calibration 53, 64, 81, 162
Ground, *see also* figure 41–6, 78, 97, 117, 133
restructuring 43, 51
structure of 53, 55, 177
Grounding 54, 67, 71, 142, 192, 197
Growth 9, 22–3, 25, 31–3, 55, 201

Hakomi method 6
Healing Tasks Model, *see also* Kepner
safety 15
self-functions 15, 23, 36, 53, 101–2
support 15
undoing, redoing and mourning 15, 160, 191, 228
Heart-rate variability 62
Hebb's axiom 28, 98
Hemisphere, *see* brain
Helplessness, *see also* defences 110–13, 115–17, 119–20, 124–6, 171, 193
collapse 93, 100, 110, 114
freeze, *see* defences
Here-and-now focus 24, 31, 75, 77–9, 87, 183
Herman, J.L. 4, 117–18, 120, 128, 151
Hippocampus, *see* brain
Holism 11, 47, 59
Hope 22, 26, 47, 118, 139, 150
hopelessness 26, 164
placebo effect in 26
Horizontalism 79, 170–1
Human potential 23
movement 14
Humiliation, *see also* shame 149, 159
Husserl, E. 79
Hyperarousal, *see* arousal
Hypoarousal, *see* arousal
Hypervigliance, *see* trauma

Identification 118
Immobilization, *see* defences
Impasse 31, 38, 112, 193
Implicit memory, *see* memory
Impulse 70, 76, 100–1, 111, 114, 123
Inclusion, *see also* dialogue 190, 193–4, 197, 206
Insomnia 46
Integrated Model of Change, *see* Change
Integration 12, 28, 32–4, 103, 143, 230
Internal Family Systems model 139
Internal locus of control, *see* control
Internal working model 131
Intersubjectivity 25, 186, 189, 207
Interoception 61, 189
Intrusion 22, 140, 150, 204, 223
flashbacks 5–6, 24, 118, 150, 192, 221
intrusive thoughts 5, 118, 150
nightmares 6, 24, 118, 150, 192
I-Thou, *see also* dialogue 25, 201
Intimacy 40, 93, 158, 177, 200, 223

Jacobs, L. 92, 120, 173, 223
Janet, P. 6, 99

Kepner, J. 14–15, 33, 35, 46, 80–1, 104
see also Healing Tasks Model
and arousal 63, 66
and body adaptation 46, 112
and boundary issues 103–4
and embodiment 33, 48, 187, 194
and energy 80, 130, 204–5
and shame 150, 158
and touch 216

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Learned helplessness 117
Limbic system, *see* brain
Locus of control, *see* control

Meaning
  meaning-making 34–5, 41, 45, 92, 212, 214
Meditation, *see* mindfulness
Memory
  explicit 86, 182, 230
  implicit, procedural 26–7, 34, 79, 93, 182, 229
  state dependent 93
  traumatic 5, 21, 75, 92, 131, 228
  unprocessed 74
Memory states
  affective 26
  somatic 96
Mentalization 224,
Merleau-Ponty, M. 79–80
Mind 8, 28, 31–2, 84, 142, 196, 226–7
Mindfulness 84–7, 200, 231
  concentration, *see* attention
  directed awareness, *see* awareness
  meditation 85, 196, 201, 206
  mindful awareness 84–8, 123, 142, 184, 200
  training 87, 143
Mirror neuron 70, 198–90
Misattunement 16, 151, 158, 172, 222
Mobilization, *see* defences
Modelling 79
Modification to contact, *see* contact
Modulation, *see also* regulation
  of emotion 57
Movement 34, 47, 67–70, 81, 113–16, 122–5, 229
Muscle 6, 114
  contraction, tension 115, 120, 204
  muscle tone, tonus 62, 66, 69–70, 114–15, 123, 180
  smooth 60

Narrative 154, 193, 204, 209, 212–14, 229–31
Nervous system, *see also* arousal 8–9, 46, 95, 98, 204–6, 209
Neural pathways, *see* brain, *see also* neuron
Neurobiology 6, 16, 59, 169, 171
Neuroscience 8–12, 14–16, 30–2, 140–1, 173, 207
  affective 10
Neuroception 95, 174
Neurochemicals 6, 9–10, 46, 60
  adrenaline 6, 64
  analgesic effects of 69, 134
  cortisol 6, 98
  endorphins 98, 134, 157
  opiates 101, 116
  oxytocin 175, 216
  vasopressin 216
Neurotransmitter 98
Neuron, neuronal 12, 28, 98, 142
  neural plasticity, growth 9, 28, 38
  neuro-imaging 9
  pruning 28
Nightmares, *see* intrusions

Objectification 106, 162
Ogden, P. 6
Organism 47, 57, 59, 120, 152, 229
Organism-environment system 57, 140, 201
Organismic self-regulation 47, 49, 58–9, 179, 208
Organization of experience 40–1, 43, 59, 78, 134, 152
  re-organization 46–7
  self-organization, *see also* self 40, 46, 59, 124, 207
Orientation 41, 72, 124, 172, 180, 229
  orienting response 95–6, 100, 130, 153

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Pacing, *see* grading, callibration
Pain 6, 23, 121, 131, 134, 157, 217
  see also neurochemicals, analgesia, body memory
Panksepp, J. 97, 157
Panic, *see* fear
Paradoxical Theory of Change, *see also* change
  self-functions associated with 32
Parlett, M. 11, 53, 132
Perception 44, 48, 77, 92, 189, 226
  alterations of during dissociation 130
Perls, F.
  influence of, 6
  life and interests of 25, 41, 85
  theories of 11–13, 23, 40, 77, 81–2, 171
Perls, L. 23, 114
Phenomenology 9, 15, 64, 78–80, 82, 85, 211
  bracketing (epoché) 79
  description 66, 79–80, 210, 212
  horizontalism 79
  observation 79
  phenomenological method 2, 31, 78–9, 83
  therapist's 216, 226
  tracking 34, 81, 144, 228
Philippson, P. 27, 30–2, 35–6, 52, 119, 135
Phobias, *see also* fear 93, 172
Physiology 9, 44, 58, 76, 157, 170
Polarities 47–50, 52–3, 63, 160, 179
Polyvagal Theory 173–4
  social engagement 102, 174,
Post-traumatic Stress Disorder, (PTSD), *see* trauma
Potency 150, 171, 178
  power, personal 48, 118–19, 123, 171
  power, therapist's 170–2
Power imbalance 118, 171
Powerlessness, *see* helplessness
Presence 96, 121, 140–2, 183, 212, 217
Present moment 75, 78, 81, 84, 123, 178
Processing 34, 67, 98, 183, 210, 228
Psychoeducation 146, 162, 170

Rape 34, 74, 100–1, 154–5, 158
Reductionism, *see also* holism 10, 30, 64, 136, 143
Reflection 27, 228
Regulation, *see also* organismic self-regulation, self-regulation 34, 59, 66–7, 78, 80
  dyadic, mutual 172, 179–82, 201, 207–8, 210, 222–3
  dysregulation 157, 162, 180, 222
  pseudo-regulation 46
  regulatory processes 70, 86–7, 134
Relational 11–13, 111, 119–20, 149–54, 221–6
  attitude 36, 141, 170–80, 210, 213–17, 230
  brain 30–1, 173
  history 118, 149, 158, 219
  style 25–6, 46, 141
  turn 12, 43
Relationship 3, 25, 120, 140, 173, 222
  rupture and repair of 221–4, 230–1
  therapeutic 53, 158, 171, 189–91, 203, 224
Repair, embodied, neuronal 8, 142–3, 160
Repetition compulsion 101
  of trauma, reliving 24, 95, 138, 154, 220, 224
Resilience 3, 53, 85, 216
  therapist 124, 176, 200
Resistance
  physical 114, 123,
  psychological 31, 112, 193, 217
Resonance 189, 196, 205–7

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Resources 52–4, 65, 86–7, 172–3
external, environmental 46, 161
internal 33, 103
part selves as 139
somatic 54, 121,
therapist 179, 186–202, 211
Responsibility 118, 125, 153–5
therapist 169, 179, 193
Retraumatization 5, 44, 115
Retroflection 94, 149
Rigidity 49–52, 64, 113–14, 203
Risk 5, 24, 31, 101, 180
assessment and management 24, 102, 162
relational 93, 156, 1 75, 177, 211, 223
Rothschild, B. 66, 77, 97, 99, 101, 183
Rupture, *see* relationship

Safe emergency 25, 51, 65, 180, 210, 228
Safety, *see also* resources 95–7, 100, 102–3, 105, 116, 120
external 174
safe place 103–4
therapist representing 181, 189, 210, 213, 220–1
Sander, L. 40, 207
Schore, A. 30, 155, 157, 206–7
Self
coherence 47, 132, 136, 231
disgust 150, 163,
embodied 33, 133, 145, 162, 214
fragmented 135, 142
as function of the field 11, 136, 189
loss of 6 120, 191
medication 134
parts of 135–6, 138–9, 143–4
self-agency 26, 120
self-care 22, 155
self-concept 35, 110, 116–17, 152–3
self-continuity 3, 150
self-functions, *see also* Healing Tasks Model 23, 35, 53, 101, 135, 173
self-harm 45, 134, 150, 156–7, 160
self-organization, *see also* organization, 40, 46, 59
self as process 135
self-regulation, *see also* organismic self-regulation, regulation 45, 59, 119, 181, 208
self-state 110, 129, 132, 135–6, 138,
self-support 111, 114, 169, 193, 208
of therapist 186–202, 194, 197
Self-world dualism 11
Sensation 54, 68, 80–2, 116, 122, 195
sensory 29, 97–8, 131, 136, 204
Sensorimotor Trauma Therapy 5–6, 16, 53–4, 63, 95, 228
Sexual violence, *see also* rape 7, 154, 159
Shame 45, 149–65, 217, 222
of body 155, 157
and helplessness 80, 117, 150
failure, sense of 55, 150
field dynamics of 158
humiliation 149, 164
internalized abuser 152
and inter-personal trauma 151
physiology of 157
polarities of 160–1
processes 149
regulatory function of 149–50, 157
self-blame 153–4
and self-harm 156
self-hatred, loathing 163
and survivor guilt 151
worthlessness, sense of 154
Shock 3, 46, 91, 94, 158, 217
inescapable 116
Siegel, D. 16, 86
and attachment 221, 230–1
and complex systems 50–1
and integration 200, 230–1

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and mindfulness 84–7, 142, 200
and mirror neurons 189
and the window of tolerance 63, 223
Splits, *see also* fragmentation 22, 176, 230
dichotomy 174
healing of 230
Social engagement, *see* Polyvagal theory
Stabilization, *see also* trauma, phases of therapy 4, 15
Stability 31–2, 50–1, 64, 70, 104, 170
Stauffer, K. 60–1, 170, 173–4
Stimulation, 60, 64, 67, 101, 228
Stimulus 29, 57–8, 67, 79, 93, 96
Stockholm Syndrome 141, 154
Stolorow, R. 74–5, 208, 220, 224–6
Stress 28, 50, 57, 98–9, 141, 224
Stress chemicals, *see* neurochemicals
Structural Dissociation Model 136–7
Submission, *see* collapse, defence
Substance misuse 4, 131, 134, 150, 162
Support 3–4, 23, 65, 141, 178, 194
environmental 104, 111, 114, 138, 151, 170
relational, 140–1, 170, 208, 210
self-support, *see* self
Survival, *see* defences

Tai chi 124, 145
Technique 10, 12–13, 81, 123, 183
expressive 25, 228
Terror, *see* fear
Thalamus, *see* brain
Theory of causality 13
Therapist
embodiment of 193–4
as organizer of experience 177
personal trauma of 193
power of 170
presence 121, 141, 178, 183, 212
as regulator of arousal 179
resources 186–201
self of 186–201
window of tolerance 195
Threat, *see* danger
Time
contemporaneity, as field principle 31, 77
continuity of, experience 43, 78, 131, 183, 214
fields of 76–7
ongoing or recursive nature of trauma reactions 14, 43–4, 92, 97, 228
past 26, 53, 73–8, 85, 105, 158
perspectives of current reality 36, 73, 80, 103, 172
present 13, 69, 73–8, 81, 145, 178
Tipping point 51, 64–5
Touch 215–16
Transference, *see also* co-creation, co-transference 175, 177
vicarious trauma 177, 190–1, 193–4
Transformation 226
Trauma
abuse 52, 115, 132, 159
abuse, childhood 98, 140, 220
approaches to therapy 4, 6, 11, 14, 58, 63
brain functioning 8–10, 28, 32–3, 94, 134,157
cognitive effects of 132, 157
complex 4–5, 119, 136, 204, 219–20
developmental 32, 219
domestic violence 98, 102, 106, 110, 159, 229
hypervigilance 44, 46, 81, 95, 118, 149
illness following 7, 10, 84, 99, 155
interpersonal 3, 48, 116

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neurobiology of, *see* neurobiology
organizing principle 41, 91, 95
post-traumatic stress disorder (PTSD) 3–5, 45, 57, 91, 159–60, 220
phases of therapy 14–15, 36
physical assault 132, 154
psychology of 115, 132
physiology of 6, 58, 157
retraumatization 5, 44, 115
sexual trauma, *see also* rape 54, 132, 150, 154
single event 3
symptoms 3–4, 21, 43, 51–2, 61, 77
transgenerational 193
vicarious ,*see* transference
war 98
unresolved, unprocessed, *see also* processing 51, 118, 220–1, 228–30
Triggers 92, 98, 103
state dependent 93
Triune brain 28–9
Trust 8, 23, 26, 151, 189, 211

Unfinished business 27, 36, 43, 138, 228, 231

Vagal
activation 60
brake 60
inhibition 174
Vagus nerve, polyvagal theory 60–1, 173–5
van der Kolk, B. 6, 57
Verbalization, *see also* alexithymia 214
Vicarious traumatization, *see* trauma
Victim 17, 44, 48, 102, 117, 151–4, 159
Vitality 23, 40, 50, 53, 60, 63

Wheeler, G. 11, 43, 78, 159
Wilkinson, M. 9, 30, 189, 214, 231
Window of Tolerance 62–6, 75, 138, 228
dysregulation 222
mutual dysregulation 222
as relational model 180, 196, 210–11
tolerance of relationship 217
Witness, witnessing 1, 151, 184, 188, 229

Yield, yielding 70, 104
Yoga 124, 145
Yontef, G. 36, 49, 75, 84, 136

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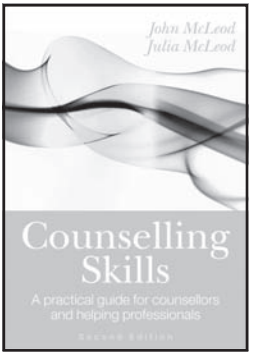

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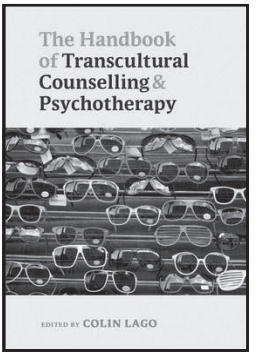

The Handbook of Transcultural Counselling and Psychotherapy
First Edition

Colin Lago

9780335238491 (Paperback)
Nov 2011

eBook also available

This fascinating book examines recent critical thinking and contemporary research findings in the field of transcultural counselling and psychotherapy. It also explores the effects of different cultural heritages upon potential clients and therapists.

Key features:

- Covers key issues such as: the implications of identity development for therapeutic work; ethnic matching of clients and therapists and working with interpreters and bi-cultural workers.
- Examines ways to overcome racism, discrimination and oppression within the counselling process.
- Provides an overview of current research within this field.

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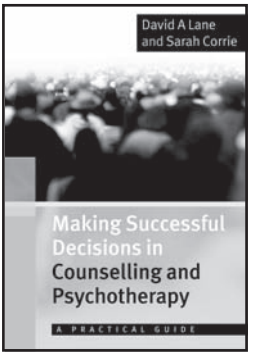

MAKING SUCCESSFUL DECISIONS IN COUNSELLING AND PSYCHOTHERAPY
A Practical Guide

David A. Lane and Sarah Corrie
9780335244348 (Paperback)
2012

eBook also available

This book examines some of the factors that are involved in making good decisions, the range of thinking skills we need in order to make effective choices and some of the factors that can prevent us from making sound decisions in our work with clients.

Drawing on both the existing literature and a range of practical exercises, *Making Successful Decisions in Counselling and Psychotherapy* provides invaluable guidance on how to tackle the task of decision-making in 'real world' counselling and psychotherapeutic settings in order to develop a systematic, effective and creative approach.

Key features:

- Draws on both the existing literature and a range of practical exercises
- Provides invaluable guidance on how to tackle the task of decision-making in 'real world' counselling and psychotherapeutic settings
- Offers advice on developing a systematic, effective and creative approach

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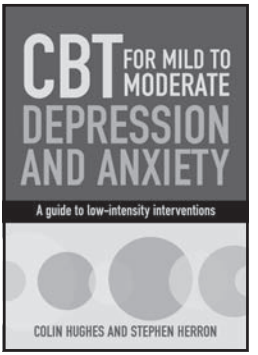
CBT FOR MILD TO MODERATE
DEPRESSION AND ANXIETY
A guide to low-intensity interventions
COLIN HUGHES AND STEPHEN HERRON

COGNITIVE BEHAVIOURAL THERAPY FOR MILD TO MODERATE DEPRESSION AND ANXIETY
A Guide to Low-intensity Interventions

Colin Hughes and Stephen Herron

9780335242085 (Paperback)
August 2014

eBook also available

Cognitive Behavioural Therapy for Mild to Moderate Depression and Anxiety provides information and support using evidence-based, low-intensity psychological treatments involving cognitive behavioural therapy (CBT) for mild to moderate mental illness. The book closely mirrors the key components of assessment, therapeutic relationship, treatment of low mood, anxiety and panic, sign posting and basic psychopharmacology

Key features:

Supports the low-intensity worker (Psychological Well-Being Practitioner) with patient self-management
Designed as a core text for Modules 1 and 2 of the Postgraduate Certificate for Low-intensity Therapies Workers (IAPT)
It is a useful practical companion to all who have an interest in or work directly with clients who experience common mental health problems

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Trauma Therapy and Clinical Practice

Neuroscience, Gestalt and the Body

"Miriam Taylor has done a simply tremendous job in articulating an expanded Gestalt approach to trauma treatment that is informed by, and integrated with, modern neurobiological approaches to trauma … This book should be read by everyone treating trauma and I expect it to become a foundational text in our field."

James Kepner, Gestalt therapist and international trainer in Gestalt Body Process Psychotherapy

"Destined to become a classic in Gestalt therapy literature. Well-written, insightful, compassionate, and practical, it will assist many a therapist."

Malcolm Parlett, formerly Visiting Professor of Gestalt Psychotherapy, University of Derby, UK

Therapy with traumatized clients can be fraught with problems and therapists working with these clients often seek greater understanding of the specific problems they encounter. *Trauma Therapy and Clinical Practice* weaves together neuroscience research and the experience of trauma, taking a fresh look at how original Gestalt theory informs our current understanding of trauma therapy. The book:

- **Places trauma and trauma therapy in a relational field model**
- **Includes material on change processes, triggers, dissociation, shame, enactment and resources**
- **Describes clearly the neurobiology of trauma and the role of the body in maintaining trauma reactions and in the recovery process**
- **Offers experiments for deepening the therapist's embodied presence**
- **Provides numerous clinical examples and an extended case study**

Miriam Taylor offers readers a theoretical basis for interventions and shows how simple Gestalt concepts can be applied in trauma therapy. By creating the conditions in which awareness, choice and vitality can grow, contemporary relational Gestalt is shown to be exceptionally well suited for trauma clients.

The book is presented in three parts covering theory, the phenomenology of trauma and the therapeutic relationship. Including a glossary for readers unfamiliar with Gestalt therapy, case studies and reflection points, this book is a thoughtful and coherent guide for trainees and practitioners in counselling and therapy.

Miriam Taylor is a Gestalt psychotherapist, supervisor and trainer. With a background in adult education and clinical work with young people, she now works in private practice and at a trauma service, and teaches at the Metanoia Institute, UK, and elsewhere.

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